MANAGEMENT OF THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

FEBRUARY 11, 1999

Serial 106–42

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

65–630 CC WASHINGTON : 2000

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
AMO HOUGHTON, New York
WALLY HERGER, California
JIM McCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri
SCOTT McINNIS, Colorado
RON LEWIS, Kentucky
MARK FOLEY, Florida

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM McDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. McNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida
LLOYD DOGGETT, Texas

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM McCRERY, Louisiana
PHILIP M. CRANE, Illinois
SAM JOHNSON, Texas
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
PHILIP S. ENGLISH, Pennsylvania

FORTNEY PETE STARK, California
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
JIM McDERMOTT, Washington
KAREN L. THURMAN, Florida

CONTENTS

MANAGEMENT OF THE MEDICARE PROGRAM

THURSDAY, FEBRUARY 11, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:35 p.m., in room 1310, Longworth House Office Building, Hon. William Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
February 4, 1999
No. HL–1

Thomas Announces Hearing on Management of the Medicare Program

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing to examine the Health Care Financing Administration's (HCFA's) ability to administer the current Medicare program and to manage the future needs of growing numbers of seniors. The hearing will take place on Thursday, February 11, 1999, in 1310 Longworth House Office Building, beginning at 2:30 p.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Invited witnesses will include HCFA Administrator, Nancy-Ann Min DeParle, representatives from the U.S. General Accounting Office, and contractors who process and audit claims for the Medicare program. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Medicare serves 37 million Americans, providing health coverage to seniors, disabled beneficiaries and kidney failure patients. According to recent analysis by the Congressional Budget Office, total Medicare spending for Fiscal Year 1999 is expected to be approximately $218 billion. HCFA, which administers the Medicare program, faces both short-term challenges and potential long-term pitfalls.

The short-term challenge for HCFA is implementing the Balanced Budget Act of 1997 (BBA) (P.L. 105–33). The BBA ensures solvency of the Medicare trust funds for the next decade by establishing new payment methodologies for skilled nursing facilities, home health agencies, hospital outpatient departments, and other service categories. In recent months, HCFA has delayed implementation of a number of BBA provisions. The long-term problems facing the program, including demographic changes and rising medical costs, are being addressed by the Bipartisan Commission on the Future of Medicare. But, unless the short-term challenges are successfully resolved, HCFA will be ill-prepared to cope with future needs of seniors.

One year ago, the Subcommittee asked GAO to do a thorough examination of HCFA's ability to meet its program management challenges and to describe any actions HCFA needed to take to accomplish its objectives over the next few years. The GAO found that the program growth and greater responsibilities were "outstripping HCFA's capacity to manage its existing workload" and made several recommendations. The Subcommittee has requested that the GAO return to HCFA, one year later, to document the current status of the agency and to note any areas of particular concern.

In announcing the hearing, Chairman Thomas stated: "Taxpayers and our nation's seniors deserve a well managed Medicare program that meets their health needs. As the Committee begins its work addressing the complex issues facing the

Medicare program, a natural place to start is with a thorough examination of the agency which administers the program.”

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address, and hearing date noted on a label, by the close of business, Thursday, February 25, 1999, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee with rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at ‘HTTP://WWW.HOUSE.GOV/WAYS MEANS/’.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS [presiding]. The Health Care Subcommittee will come to order.

This is our first hearing obviously of the 106th Congress. We’re going to focus on the management of the Medicare Program and its administering by the Health Care Financing Administration.

It's our honor once again to have as our lead off witness, the administrator of the Health Care Financing Administration, Nancy-Ann Min DeParle. And, as I've often said, one of these days, I'm going to reverse the order of the hearing. You get to go first this time. But oftentimes when we have additional panels, their written testimony references concerns which I think would be more properly addressed by having the administrator respond to those. So we have to kind of make it happen before the panel gets to testify. And the administrator came in after we began the organizational meeting, but I'm going to talk to her about that because of pending time constraints. I do think that kind of a structure might be more useful when we're dealing with some of the issues that we'll be facing for example today. Oftentimes people will pose questions. There are answers to those questions, but if we don't get to answer them, they seem like more significant questions than they are.

We are, as was indicated, waiting for the Bipartisan Commission on the Future of Medicare to hopefully provide some solutions for the long-term solvency of the program. We're going to be looking at our ability to deal with short-term issues, including obviously the implementation of the Balanced Budget Act of 1997. And, as significantly, getting an update on the so-called Y2K ability for us to respond because, frankly, if we can't handle the short-term structural concerns, we're not going to be as prepared as we would like to be for the long-term changes.

All of us are cognizant of the fact that this program needs to be restructured. The degree to which it needs to be restructured, the manner in which it needs to be restructured is obviously open for discussion.

Following the administrator, we will, as per our usual script, have Dr. Scanlon, head of the General Accounting Office's Health section, review management and practices. There has been extensive interviewing. And it was clear from the testimony, if the members read Dr. Scanlon's testimony, that HCFA personnel were more than open and cooperative in discussing those things that have been successful and some of those things that have not been successful.

And then, as I said, the final panel will be some frontline private contractors who deal with contracting on the A and the B side of Medicare to provide us with the view from the private contractors day-to-day functioning process within the structure. And we look forward to hearing from them as well.

So prior to your testimony, I call on the gentleman from California, the Ranking Member, for any comment he may have?

Mr. STARK. Thank you, Mr. Chairman. I just want to comment about enforcing the rules regarding testimony. I was never very successful in the past, but perhaps the Chair could be. A solution would be to be very tough about requiring witnesses submitting written testimony, to submit it 24 to 48 hours before the hearing and to distribute it to all of us so we have the night before to go through it, or at least have our staffs do so. And, it would seem to me, when we have administration witnesses, I would think there would be nothing wrong with having the testimony shared among the prospective panels. There's really no reason they can't get it in. It's just that we all procrastinate.

So I would urge the Chair, and I would be glad to join with him, to urge all witnesses and panel members to get their testimony in on time. I think it would make the hearings more interesting for all of us.

I would like to congratulate you for this hearing and congratulate the administrator, Nancy-Ann Min DeParle, for the work that she's done. It was recently reported that her error rates dropped from 11 to 7 percent, and it saved us about $10 billion. Now, if she could just do that every year for the next several years, we would be home free. However, she is still, in my opinion, overwhelmed by workload and criticism. And it's interesting to note that under her administration. HCFA, the Health Care Financing Administration, is actually smaller today than it was 20 years ago when it was created. So as we've increased the responsibilities, we have not increased the authority and the flexibility to expand the staff and support that they need to keep up with the work.

It's essential that they look beyond this Y2K problem to modernizing their entire system and use market measures to obtain fairer prices in buying the services. The contracting rules also should be updated. They were last written in 1965. For several years, I have worked with the Appropriations Committee to make sure that HCFA's administrative appropriations have been fully funded. And while I've praised HCFA for low overhead, I've also cautioned that we may have reduced their overhead too much.

I would like to paraphrase for a minute and submit for the record a letter, an open letter in *Health Affairs*, by Stuart Butler, Bill Gradison, Marilyn Moon, Uwe Reinnard, Bob Reischauer, Bill Roper, John Rother, and Gail Wilensky. This is an unusual group to be agreeing with each other and sending a letter. And without belaboring the point, they point out that Medicare spending has increased in 1997 by tenfold, but the agency's work force is even smaller. They hammer on that point and they criticize both, or all, previous administrations for the failure to provide the agency with adequate administrative resources. They say that we must reexamine the funding, management, and oversight and to do anything else is short-changing the public and leaving HCFA in a State of disrepair.

I think we can all find places to criticize, but I think we have to look here. We don't have the authority on this Subcommittee provide HCFA with the money and the resources they need. But, I certainly think we would probably be—and I say this with all trepidation—that we probably are in a better position to analyze HCFA's need than our colleagues on the Appropriations Committee. And I hope that I'll see all the Members of this Subcommittee joining with me when we go to the Appropriations Committee and the Budget Committee to see that HCFA is appropriately funded. You can't expect them to do the job we want, Mr. Chairman, unless we provide them the resources. And I don't say that to assess any blame. Since we can't provide the resources, we have to go out and lobby for HCFA and be an advocate for them once we tell them what to do.

Thank you very much for having this hearing.

Mr. KLECZKA. Mr. Chairman.

Chairman THOMAS. The normal rules of the Subcommittee is that opening remarks are reserved for the Chairman and the Ranking Member and other Members may submit written statements. But the gentleman from Wisconsin?

Mr. KLECZKA. Mr. Chairman, we've been joined by a fellow Member of the Committee, Mr. John Tanner from Tennessee, and if the Chairman agrees, he would like to offer a welcome to the administrator since she hails from his State?

Chairman THOMAS. And the Chair would also welcome the gentleman from Georgia once again, Mr. Lewis. I would tell the gentleman that if he does the introduction, the Chair would like to take a brief time between the introduction and the administrator's testimony, but I don't want to step on the Tennessee welcome to the administrator. Mr. Tanner.

Mr. TANNER. Thank you, Jay. Thank you, Mr. Chairman. And I want to—Ms. DeParle has been a long time friend. She's from Tennessee. She worked in administration down there when I was in the legislature. I saw an article in the Los Angeles Times just the other day about how the error rate in billing has been cut in half during your tenure or shortly after you came. And this Subcommittee I know is anxious to hear you, and I just wanted to stop by and welcome you. And we appreciate the job you're doing here for us.

Ms. DEPARLE. Thank you so much.

Mr. TANNER. Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman. Let the Chair say that this is an important Subcommittee. Ways and Means has some of the brightest and best Members in the House. This Subcommittee, in my opinion, selects from that pool. And that over the years we have done some very, very difficult work. The work is on behalf of the seniors in the United States and the Chair has noted, including himself at times, that perhaps the way in which the meetings have been conducted probably were not at the level of the responsibility we feel to the seniors.

In casting around to come up with a way in which we would not be disruptive of the business of the Subcommittee, in the past the Chair has noticed that the way that it has evidenced itself has been that Members would follow other Members' responses. The Chair's initial reaction was to go with the NBA season and provide Subcommittee Members with whistles. That probably would be more disruptive than the suggestion I came up with since the NFL season has just ended. The idea would be that the Chair would pass out to Members a penalty flag in which if any Member, including the Chair, were to make remarks which clearly would be out of bounds using the test of the importance of the mission in front of us, the Chair would say that a single flag from the minority side probably is not as relevant as a flag from both the minority and the majority side. [Laughter.]

However, two flags from either side should be sufficient. The goal being that we don't take up the Committee time in terms of the verbal fencing, but that you simply let it be known that a penalty in your opinion has been committed and then we move on. I think that will at least create an atmosphere, if not of civility, no severe physical wound will occur from this. Hopefully, a bit of a psychic damage will occur and we can move forward.

With that, I would ask the gentlewoman from the State that has the national champions in football, and that's purely coincidental, give us her report. Thank you for your report in writing. It will be submitted to the record in it's entirety, and the administrator has our ear to present her information as she see fits.

Welcome, Nancy.

STATEMENT OF HON. NANCY–ANN DEPARLE, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Ms. DEPARLE. Thank you, Chairman Thomas and thank you, Mr. Stark and other distinguished Members of the Committee.

I appreciate being here today to discuss the progress that we're making in strengthening the management of the Health Care Financing Administration. I also want to thank my colleagues at the General Accounting Office for their careful evaluation and advice. This is the second of these evaluations that this Committee has sponsored, and they've been extremely helpful to me as I look at the problems facing the Agency and how I should be addressing them.

I have now been the administrator of the Health Care Financing Administration for a year. When I came before you in January of last year, I told you that I had several immediate goals and they were first to strengthen Medicare, starting with implementation of the 335 provisions of the Balanced Budget Act that had recently been passed. Second, to ensure that our computer systems were Y2K compliant, that there would be no disruption of services to beneficiaries or claims payment to providers because of the computer system problem. Third, sharpening our focus on fraud, waste, and abuse, reducing the number of claims that Medicare pays inappropriately. And, fourth, launching the new children's health insurance program, which was one of the signal achievements of the last Congress in providing health insurance coverage to millions of low-income children whose families couldn't afford it.

What I've tried to do in the past year are really three things: First, to set forth clear goals for the agency, and those are the ones that I've outlined for you last year and we've stuck to this year.

Second, I brought in a new leadership team, many people from the private sector to help us achieve those goals. And to name just a few of them, we now have a physician who was a practicing internist for more than 20 years, Dr. Bob Berenson, and also ran a PPO, who is now the head for the Center for Health Plans and Providers and is leading us in the implementation of the Balanced Budget Act. We have a geriatrician, Dr. Jeff Kang as the chief clinical officer, leading our efforts in quality and working to establish a more open and accountable Medicare coverage process, which I know is one of the issues of particular interest to you, Mr. Chairman. We have a gerontologist, Carol Cronin, who specialized in providing health care education for consumers and for large corporations and their employees, running our Center for Beneficiary Services which was created as part of the reorganization. And she is leading the development of the national Medicare education program. And we have a veteran of the Inspector General's Office, Penny Thompson, who is leading our efforts to improve program integrity in the Medicare and Medicaid Programs.

Finally, with this team I've tried to provide leadership to the 4,000 HCFA employees who are working to achieve the vision that I have for the agency, which is a more efficient, responsive, and effective agency. Our job is enormous and it's far from done.

And if you'll allow me one more reference to Tennessee, Mr. Chairman, I come from the hills of east Tennessee and we have a saying there. When someone asks for directions, we tell them, "You go over those hills and then there's some more hills." That's how it is at the Health Care Financing Administration as well. When you're providing health insurance coverage to 74 million Americans; when you're working with 1.6 million providers; when you're the steward of more than $300 billion a year in public dollars, there are many challenges and there are new challenges every day. But with your help and with Congress' help, we have been making solid, steady progress.

Since I was here last year, we've implemented some 188 of the 335 provisions in the Balanced Budget Act. And I'm not counting there some of the things like provider updates that have been partially implemented but we have to do it again this year.

We're making substantial progress on the other 147 provisions. And to do this, last year we published 92 regulations, which I think has to be something of a modern record for us. In fact, today we're publishing a rule clarifying several aspects of Medicare Plus Choice. It's what we refer to as the "mini-rule" that responds to some of the concerns that plans had about the regulation that we put out last July. We're also announcing today the establishment of a new Citizens Advisory Committee on Beneficiary Education. And we're soliciting nominations from the public and from all of you for people who can help us to make sure that we're keeping the beneficiary first as we establish our beneficiary education program.

We have made enormous progress on the Y2K computer problem. As of December 31, 1998, all 25 of our internal mission critical systems and 54 of 78 external mission critical systems had been repaired, tested, and certified. We are on track to fix and certify any remaining systems by March of this year.

We have worked aggressively with States, providers, Members of Congress, and others to implement the new children's health insurance program. We've approved plans for 47 States and also the District of Columbia and two territories.

We have made I think good progress in improving our record on program integrity. As Mr. Stark noted, on Tuesday the Inspector General announced that the Medicare error rate, the rate of claims that we pay inappropriately had dropped to 7 percent, I'm not satisfied with 7 percent, but I am happy to see that we had a 45 percent drop in 2 years. And, again, I thank you for the support that you've given us in making those efforts.

And, finally, we launched a new initiative last summer to improve our enforcement with the States of quality in our Nation's nursing homes. There are 17,000 nursing homes in the country, and many, many of our fellow Americans are living there and deserve a better quality of life.

I appreciate the help that many Members of this Committee have given me over the past year. Many of you have worked with me personally to identify problems as we've been implementing the Balanced Budget Act. You've helped us get the resources to deal with those problems, and you've been understanding about the difficulty and the magnitude of the job that we're trying to do. We're going to, of course, be asking you for more help this year, both with our budget and also for help with some management changes that we would like to make. Mr. Stark referred to one of them, contractor reform. We would like some more flexibility to deal with some of the problems we have, and we think that would help us to enhance our capacity.

We share the same goals I think. We all want Medicare and Medicaid to be strong, well-managed, and fiscally sound. We all want to put the beneficiary first. And we all share a vision of HCFA as more efficient, accountable, and a more effective agency.

On behalf of our beneficiaries and on behalf of the 4,000 people at the Agency who worked very hard last year to make progress, I want to thank you for your interest and support and for your help in achieving the vision I have of a more effective HCFA.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

Statement of Hon. Nancy-Ann DeParle, Adminstrator, Health Care Financing Administration

Chairman Thomas, Congressman Stark, distinguished committee members, thank you for inviting me to discuss our progress in strengthening Health Care Financing Administration (HCFA) management of Medicare and our other programs and responsibilities. I would also like to thank the General Accounting Office (GAO) for its evaluation and advice on this and other subjects over the past year since I became Administrator.

HCFA is the nation's largest health insurer, providing coverage to about 74 million people. Our workload has grown immensely with the Balanced Budget Act (BBA) of 1997, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the challenges of complying with Year 2000 computer issues, fighting fraud, waste, and abuse, and meeting the needs of the ever-growing number of beneficiaries we serve.

Our programs—Medicare, Medicaid, and the new Children's Health Insurance Program—now provide more coverage, more health plan options, and more health care security to Americans than ever before. Together they will pay for an estimated $335 billion in benefits in 1999, and represent the Federal Government's third largest outlay. Medicare alone now processes about 900 million claims each year, is the nation's largest purchaser of managed care, and accounts for 11 percent of the federal budget.

We are working to meet our management challenges despite a rapidly growing workload. I want to thank this Committee for its support of the President's request for HCFA last year. The growth in our workload over the past three years is unprecedented in HCFA's history. Our discretionary program management appropriation has remained relatively flat in recent years. The Congress did provide the Administration's full request for an increased management appropriation for fiscal year 1999, which represents a good first step. The President's FY 2000 HCFA budget request builds on last year's appropriation, and includes user fee proposals to allow better program efficiency. We are eager to work with Congress to secure adequate funding to meet all of HCFA's responsibilities in fiscal year 2000 and beyond.

HCFA spends less than one percent of Medicare benefit outlays on Medicare program management, and less than 2 percent on administrative costs overall, compared to private sector administrative costs of 12 percent and higher. Some of the difference is due to efficient management and economies of scale. However, our growing workload makes it necessary to secure adequate funding to continue to improve our management of the program.

We are accomplishing a great deal with our resources. In the past year, we have:

• published 92 regulations and Federal Register notices implementing important Congressional directives, beneficiary protections, and taxpayer savings, including the savings in the Balanced Budget Act that are critical to extending the life of the Medicare Trust Fund;
• responded to nearly 7,000 pieces of Congressional correspondence, and delivered 15 official Reports to Congress;
• participated in more than 1,000 events around the country to help beneficiaries understand health plan changes;
• made remarkable progress in addressing our Year 2000 challenge, and participated in more than 100 events around the country to help providers address this challenge;
• made major strides in fighting fraud, waste and abuse and preventing payment errors;
• approved 50 Children's Health Insurance Plans which States expect to cover more than 2.5 million children;
• issued more than 50 program guidance letters to State Medicaid and health officials on issues such as the managed care reforms in the BBA;
• implemented a carefully planned National Medicare Education Program to help beneficiaries understand their rights and options, and make informed health care decisions;
• converted the vast majority of Medicare HMOs to the new Medicare+Choice program, and added 10 new plans and expanded service areas for another 10 plans.
• worked closely with state insurance regulators on important Health Insurance Portability and Accountability Act consumer protections;
• updated our Strategic Plan to reflect our expanded mission, set clear goals and specific objectives, and establish performance measures to gauge our progress; and
• begun a nationwide initiative to improve nursing home oversight and care.

MANANGEMENT REFORMS

We have made significant strides in improving HCFA management since I testified before this Subcommittee on this issue last year. In the past year I have tried to articulate a clear vision of a more efficient and effective HCFA. I brought in a new leadership team to help me achieve these goals. And we have taken a number of steps to help us do more and be more efficient, effective, responsive and accountable. In addition, the fiscal year 2000 President's budget builds on these steps by seeking new flexibilities to manage our programs more effectively.

Our first step was to completely reorganize our agency to focus on serving beneficiaries and outside partners like plans, providers and States. Our structure is now built around our "customers" rather than internal issues. This has sharpened our focus on the changes in our mission, and is helping us be more accessible and responsive. Most important, for the first time ever we have a Center for Beneficiary Services to ensure that we have beneficiaries first in mind in every decision we make and every action we take.

We brought in new staff and leadership from the private sector.

• A computer scientist and security expert from the Los Alamos National Laboratory serves as our first-ever Chief Information Officer and heads our information technology team and Year 2000 efforts.
• An internist who helped establish a private sector preferred provider organization health plan now leads our Center for Health Plans and Providers.
• A geriatrician who was a private sector managed care plan medical director is our Chief Clinical Officer and heads our Office of Clinical Standards and Quality.
• A gerontologist who ran a private sector firm devoted to helping corporations educate their workers on health care is leading our Medicare beneficiary education program.
• A physician who has worked as a Medicare contractor medical director is in charge of implementing much stronger oversight of Medicare claims processing contractors, with a special emphasis on making sure contractors meet their responsibility to be diligent in preventing fraud and payment errors.
• A physician is leading a review of all our rules and regulations to see where they can be simplified, clarified, and refined to reduce administrative burdens on physicians and better meet beneficiary needs.
• And a former State insurance department director is coordinating our new State-level responsibilities under the Health Insurance Portability and Accountability Act.

Overall last year we doubled the number of physicians at the agency and hired about 450 new employees to replace retirees, fill new positions, and provide us with fresh private sector insight and expertise.

We have taken steps to make sure policies are applied fairly and evenly across the country. We have strengthened communication between leaders of our Regional Offices and our main policy and operations divisions. And we have established "Product Consistency Teams" to make sure that policies and procedures are applied uniformly across the country.

We are creating new advisory committees, pursuant to the Federal Advisory Committee Act, that will continually bring outside insight and expertise to our agency. They will also help bring more openness to our operations and help us make sure we are managing our programs to meet beneficiary needs.

- One advisory committee, the Citizens Advisory Panel on Medicare Education, will help us make sure we are giving beneficiaries the information they need to be informed consumers in the new Medicare+Choice program.
- Another advisory committee, the Medicare Coverage Advisory Committee, will foster openness and public input in our coverage decision-making process. It will include experts in medicine, biology, public health, ethics, economics, data analysis, and other professions, and work from objective medical evidence for recommending when Medicare should pay for new medical treatments and services.
- A third advisory committee, announced in the President's budget, will include private sector business and management experts who can advise the Administrator on how to improve HCFA's business processes and incorporate innovations that will better serve our beneficiaries.

We are also seeking new flexibilities to strengthen our capacity to manage our programs. The President's budget calls for:

- an assessment of our personnel skill mix and an evaluation of increased flexibilities in personnel matters that would help us pay competitively, hire the right staff to serve beneficiaries, and hold employees accountable for results;
- increased accountability by establishing the outside advisory committee discussed above to advise the Administrator on management issues and by regularly reporting to Congress and the public on the status of programs and initiatives;
- reengineering our relationship with our Regional Offices and with the Department;
- allowing Medicare use market forces to prudently purchase care and services so we get the best quality and price for beneficiaries; and
- reforming Medicare contracting authority so we can hire from a broader pool of private businesses to handle Medicare claims and move toward a more competitive and effective procurement environment.

These reforms are needed to help us manage our programs efficiently and with a sharper focus on serving beneficiaries and ensuring access to high quality care.

THE YEAR 2000

Meeting the Year 2000 computer programming challenge must be our highest priority. HCFA got a late start but we are now making substantial progress in addressing this critical challenge. I want to assure beneficiaries that they should not worry. We are working with the health care community to assure that beneficiaries will continue to have access to the care they need. And I want to assure health providers that HCFA and its contractors will be prepared to pay their claims come January 1, 2000. However, providers must act now to be sure that their computer systems are fixed so they can submit claims to us. We continue our work and testing, but I am confident that we will be ready well before January 1, 2000. To date:

- all of our 25 internal mission critical systems are now certified as Year 2000 compliant ("certified" means that independent experts have overseen renovations and testing and validated that they have been done properly);
- our 78 external mission critical systems that our claims processing contractors use to pay bills are fully renovated, and more than 70 percent are certified as compliant. We have experts on-site every day, monitoring and assisting contractors who have significant amounts of remaining Year 2000 work;
- systems for about 95 percent of Medicare managed care plans are reported compliant; and
- we have completed the first round of certification testing on twenty-four of our sixty non-mission critical internal systems.

There is no question that we have faced an uphill battle in achieving Year 2000 compliance. We have a substantial amount of work remaining this year to test and validate our systems. We are working to encourage and help providers meet their Year 2000 responsibilities, and to help beneficiaries understand what they need to know about the Year 2000 issue. We also must work to renovate our non-mission critical systems, and to make temporary fixes permanent.

A number of key steps are getting us where we need to be. They include:

• building a “War Room” to track Year 2000 efforts within the agency and with partners across the country so we know the current status of all essential Year 2000 projects;

• negotiating contract amendments with more than 60 claims processing contractors to establish clear Year 2000 requirements;

• establishing contractor oversight teams to closely monitor and manage Year 2000 work on-site and full time for claims processing contractors who most need help;

• hiring independent expert contractors to give us greater assurance that Year 2000 work is done properly by us, our claims processing contractors, and States; and

• helping health care providers through a broad outreach campaign that includes mailings, publications, an Internet site, a speaker’s bureau, and a wide range of other efforts.

I must be clear, however, about what HCFA can and cannot do. We are responsible for all our own systems, our claims processing contractors’ systems, and data exchange interfaces among all of these systems and the systems of States, providers, banks, phone companies, and other partners. We do not have the authority, ability, or resources to step in and fix systems for others, such as States or providers. And that leads to a rather substantial concern.

It is not enough for HCFA alone to be ready for the Year 2000. Health care providers must be Year 2000 compliant in order to bill us properly and continue to provide high quality care and service to Medicare beneficiaries. States also must be Year 2000 compliant for Medicaid and CHIP programs to continue uninterrupted service. Our monitoring indicates that some States and providers could well fail. We are providing assistance to the extent that we are able, but that likely will not be enough. This matter is of urgent concern, and literally grows in importance with each passing day.

Our own progress in meeting the Year 2000 challenge is due in large part to the outstanding effort and commitment of staff throughout HCFA and at our claims processing contractors. I also want to thank the Secretary and my colleagues at the Department of Health and Human Services, especially the HHS Inspector General, for their support. We have been greatly aided by wise counsel from the General Accounting Office and, importantly, by the expert independent validation contractors the GAO recommended we hire to ensure that Year 2000 work is done correctly. And, without question, we could not have come so far so quickly without the timely support and funding that Congress has provided.

FIGHTING FRAUD AND PAYING RIGHT

We are making unprecedented strides in promoting program integrity. This includes both fighting fraud, waste and abuse, and making sure we are paying right. We have set new records for restitutions, convictions, and exclusions of problem providers by working more closely with our law enforcement partners. Since 1993, these efforts have saved taxpayers billions of dollars and increased health care fraud convictions by more than 240 percent. We also are addressing honest errors in billing and payment through good program management and business practices, improved education and communication with providers, and correcting payment errors regardless of the reason for them.

We have developed a comprehensive program integrity plan to build on these successes. The plan calls for:

• increasing the effectiveness of medical review by increasing the overall level of review, targeting it on problem areas, hiring additional physicians to improve its effectiveness, using more computer “edits” that prevent improper payments, training employees to develop cases for prosecution, evaluating local policies to see where national policy may be needed, and measuring how well individual contractors perform medical reviews;

• stepping up efforts to help providers comply with rules, establishing clear enrollment and periodic reenrollment requirements; and requiring bonds for certain types of providers.

• proactively addressing potential program integrity problems before they occur in the new programs, benefits, and payment systems created under the BBA;

• planning how to deal with potential program integrity problems related to the Year 2000 computer issue; and

• focusing on special areas of concern, such as inpatient hospital care, congregate care such as nursing homes and assisted living centers, community mental health centers, as well as addressing the unique program integrity issues related to managed care.

We further expect our program integrity successes to increase this year as we begin to use new authority to hire special program integrity contractors. We plan to hire payment safeguard contractors to focus on medical review, fraud case development, cost report audits and related program safeguard functions as needed; a coordination of benefits contractor to consolidate all activities associated with making sure Medicare does not pay for claims when other insurers are liable; a statistical analysis contractor to provide on-going analyses to help detect fraud; and managed care integrity contractor(s) to target issues unique to health plans.

We expect to start these new, special program integrity contractors on the job this year. This is important, because the HHS Inspector General reports that not all Medicare's claims processing contractors are effectively fighting fraud and abuse. We have responded by including fraud case developing in the scope of work for our new special program integrity contractors, and by ordering existing contractors to report all suspected fraud cases immediately to the HHS Inspector General. But, clearly, we need to do more.

That is one reason why the President's budget proposes a new legislative package to fight fraud, waste and abuse that will save about $3 billion over 5 years. It includes eliminating excessive reimbursement for drugs, putting stricter controls on outpatient mental health services, requiring other insurers to report all Medicare beneficiaries they cover so Medicare can make sure it does not pay bills that should be paid by other insurers. It also include more authority to choose the most effective Medicare contractors.

BALANCED BUDGET ACT

The BBA includes 335 provisions that affect our programs, with savings that are critical to achieving a balanced budget and extending the life of the Medicare Trust Fund for 10 years. We have fully implemented more than half of those provisions, and many more are partially implemented.

We have implemented provisions for Medicare coverage of new preventive benefits, including expanded coverage for test strips and education programs to help diabetics control their disease, bone density measurement for beneficiaries at risk of osteoporosis, and several colorectal cancer screening tests. We also expanded preventive benefits for women so Medicare now covers a screening pap smear, pelvic exam and clinical breast exam every three years for most women, and every year for women at high risk for cervical or vaginal cancer. And Medicare now covers annual screening mammograms for all women age 40 and over, and a one-time initial, or baseline, mammogram for women ages 35–39, paying for these tests whether or not beneficiaries have met their annual deductibles.

We are implementing important demonstration projects designed to test whether market forces can help Medicare save money and promote high quality care. We will soon begin a test in Polk County, Florida of competitive bidding as a way to get the best quality and price for durable medical equipment and supplies. Bidding documents are scheduled for release this week, and a conference for potential bidders is scheduled for February 23. A toll-free hotline (888–289–0710) is available to answer beneficiary and provider questions about the project.

We will soon begin a test of competitive pricing for managed care, in which a bidding process will be used to set rates for Medicare+Choice plans in two local markets. A Medicare Competitive Pricing Advisory Commission, chaired by General Motors Health Care Initiative Executive Director James Cubbin, has made recommendations regarding key design features of the project, and selected the markets of Phoenix, Arizona and Kansas City, Kansas and Missouri, as initial demonstration sites.

We also are developing important new payment systems that include incentives to provide care efficiently. We have already implemented a new prospective payment system called for in the BBA for skilled nursing facility costs. Similar prospective payment systems are being developed for rehabilitation hospitals, home health care, and outpatient hospital care.

Medicare+Choice

We are implementing the new Medicare+Choice program, which was also mandated by the BBA. It allows Medicare beneficiaries to select from a wide range of plan options available in the private sector today. It requires a massive new beneficiary education campaign, and includes important new protections for patients and providers, as well as statutory requirements for quality assessment and improvement.

We believe very strongly that managed care is good as a voluntary option next to traditional Medicare. Medicare managed care enrollment has nearly tripled under the Clinton Administration, from 2.3 million when the President took office to now 6.8 million. We are taking steps to help beneficiaries understand their new options and encourage plans to provide these new options.

We have launched the National Medicare Education Program to help beneficiaries understand the program and receive accurate and unbiased information about their benefits, rights, and options. The campaign includes:

- mailing a Medicare and You handbook to explain new benefits and health plan options;
- a toll-free "1-800-Medicare" call center with live operators to answer questions and provide additional print information on request;
- a consumer-friendly Internet site, www.Medicare.gov;
- a program to teach partners in other organizations that serve Medicare beneficiaries how to teach others in their organizations and communities to explain the changes;
- enhanced beneficiary counseling from State Health Insurance Assistance Programs;
- a national publicity campaign;
- a multitude of state and local outreach efforts; and
- a comprehensive assessment of these efforts. An initial pilot test was begun in five states in 1998. Results will help to refine the program for a full-scale, national campaign in preparation for the 1999 open enrollment period beginning in the fall.

We are taking several steps to reach out to health plans to encourage participation in the Medicare+Choice program. Last summer we held outreach sessions attended by more than 1,500 plan representatives. And we are strengthening lines of communication with plans. I have named a high-level point person within HCFA whom plans can call directly if they have trouble resolving issues through normal HCFA channels.

We have converted the vast majority of Medicare HMOs—more than 300—to the new Medicare+Choice program. We have approved a total of 10 new Medicare+ Choice plans and 10 service area expansions for existing plans since November. We are currently reviewing another 28 new plan applications and 19 service area expansion applications. The newly approved plans include provider sponsored organizations, which are HMOs run by hospitals and physicians rather than insurers. One of these plans is the first to enter Medicare with a federal waiver from State licensure, which is allowed for the first time ever under the Medicare+Choice program. We have also taken all necessary steps so that Medicare beneficiaries can be offered Medical Savings Account options, as well.

We have taken several additional steps to implement Medicare+Choice. We have developed new beneficiary and plan enrollment systems, payment systems, appeals and grievance procedures, and quality assurance mechanisms. And we are collecting data that will be used to phase in "risk adjustment" to meet the BBA requirement that payments to plans take into account the health status of individual enrollees.

We will soon publish refinements to regulations which improve beneficiary access to timely information about plan changes that affect them. The refinements also address plan concerns and should help encourage plans to offer more options to Medicare beneficiaries.

And, to further facilitate plan participation, the President's budget gives plans two additional months to file the information that we use to approve benefit and premium structures. This "Adjusted Community Rate" (ACR) data would not be due until July 1, rather than May 1. July 1 is the latest we can accept, process, and approve premium and benefit package data and still mail beneficiaries information about available plans in time for the November 1999 Medicare+Choice open enrollment period.

While I am concerned about the business decision that some Medicare HMOs made last October to pull out of the program this year, it is important to put those business decisions in context. Some of the plans that withdrew had market positions or internal management issues that made it hard for them to compete. And they faced rising prescription drug prices and other commercial pressures. Many of the disrupted beneficiaries had several other plans to choose from, and all but 50,000 had at least one other plan option.

It is our understanding that the Federal Employees Health Benefits Program (FEHBP) experienced a similar rate of plan pullouts. We have observed instances where plans that withdrew Medicare service from specific counties also withdrew their FEHBP service in many of those same counties. As mentioned above, the majority of Medicare HMOs converted to the Medicare+Choice program, we have approved 20 new plan and service area expansions approved since November, and are now reviewing applications from another 47 plans that want to get into or expand their role in Medicare+Choice. This suggests that plan withdrawal decisions have more to do with internal plan and larger marketplace issues than with Medicare rates or regulations.

Still, the President's budget does include proposals to protect beneficiaries from disruption by plan withdrawals. Beneficiaries need earlier notification of plan withdrawals, and broader access to supplemental Medigap polices if they are forced to return to fee-for-service coverage.

OTHER INITIATIVES

We have several other important initiatives underway addressing children's health insurance, consumer protections for Medicaid beneficiaries in managed care, consumer protections in the private insurance market, and consumer protections in nursing homes.

Children's Health Insurance Program

We are implementing the new Children's Health Insurance Program, or CHIP. We have approved 50 State and Territory plans, which States expect to cover more than 2.5 million children, most of whom are in working families who do not earn enough to afford coverage for their children. Amendments expanding state plans have been approved for nine states, and we are now reviewing another nine amendment proposals, which should cover even more children.

Medicaid

We have proposed regulations to implement BBA provisions mandating strong, new patient protection and quality improvement rules for managed care plans that now serve about half of all Medicaid beneficiaries nationwide are now enrolled in managed care. This is a comprehensive and important change that should not affect States or plans ability to make Year 2000 systems changes. We also have sent State Medicaid Directors more than 50 letters with guidance as other Medicaid-related BBA provisions became effective. These letters address provisions that help States expand assistance to low-income Medicare beneficiaries, let States cover working disabled people with incomes up to 250 percent of poverty, allow states to mandate that most Medicaid beneficiaries enroll in managed care without obtaining a federal waiver, and many others.

Health Insurance Portability and Accountability Act

We have undertaken tasks under the Health Insurance Portability and Accountability Act that are well outside our traditional responsibilities. We are charged with overseeing protections for individuals with preexisting conditions and other broad private sector insurance reforms, and we must enforce these reforms in States that fail to do so. To date, we are enforcing all provisions of the law in Rhode Island and Missouri, and several major provisions in California. As many as 30 other States may not have implemented all provisions of the law. Our fiscal year 2000 budget request includes resources for direct enforcement and close coordination with State insurance departments that are necessary for us to meet our new obligations.

HIPAA also charges our agency with improving and protecting health care data that is exchanged electronically. We are now reviewing several thousand, often highly technical, comments on Notices of Proposed Rule Making regarding a national provider identifier system, an employer identifier system, electronic transactions and code sets, and electronic data security. We expect to soon publish Notices of Proposed Rule Making for a health plan identifier system and for electronic claims attachments.

Nursing Home Initiative

We have also undertaken a new initiative to improve oversight and quality of nursing home care. We are working with States to improve inspections, cracking down on homes that repeatedly violate safety rules, focusing on prevention of physical abuse and neglect such as dehydration and malnutrition, and posting nursing home quality ratings on the Internet. These reforms build on progress made since 1995, when we began enforcing the toughest nursing home regulations ever. The Clinton Administration will again submit legislation to Congress to require criminal background checks of prospective nursing home employees, establish a national registry of nursing home workers who have abused or neglected residents or misappropriated residents' property, and allow more types of nursing home workers to help residents eat and drink during busy mealtimes.

CONCLUSION

We are making substantial progress in meeting our challenges and better managing the programs that so many millions of Americans rely on for health care coverage. Clearly, we have much more to do. That is why we are implementing the many management reforms discussed in this testimony. That is why the President's budget includes provisions to increase our flexibility in procurement and personnel matters, and to establish an official advisory committee to help us stay on top of the rapidly evolving health care marketplace. And that is why I am grateful for the advice and assistance of this Committee and of the General Accounting Office. I thank you again for holding this hearing, and I am happy to answer your questions.

Chairman THOMAS. Thank you, Nancy. And we have in the past covered those concerns that previous administrators had thought they were solving the potential Y2K problem with an administrative, sweeping administrative change which eventually was swept out the door rather than going into effect. And I don't want to spend a lot of time on that, but it is something that we do have to consider in terms, as you indicated, although it seems a lot longer than that, you have been there only 1 year? OK. It seems like three already. You did come in at a time when not only the BBA and all of the changes included in that which would have been more than sufficient, you came in following a reorganization which people hadn't physically been moved to where they were supposed to go and the Y2K problem as well. And I just personally want to say that notwithstanding those factors, which have to be dealt with, and, frankly, have not been dealt with as well as sometimes we thought they should have been, you personally, in my opinion, have done an excellent job.

Ms. DEPARLE. Thank you.

Chairman THOMAS. You recall the last time that we had the audit and I tried to indicate that whatever the amount, $22, $23 billion, whatever it was, should not automatically be placed in the waste, fraud, and abuse column. That, in fact, I wasn't going to use that to beat up on the Administration because I thought a lot of it could be attributed to improper coding, not understanding exactly from an administrative point of view where it was to be classified, and it was all rolled up together. At the same time, I don't believe, if you'll allow me, that we've dropped that dramatically in our reduction of fraud and abuse. My guess is that the second time around we wound up finding a home for all of those mis-filed, that had wound up as part of the total lost cost. Is that true? Do you have any way to quantify the portion of the reduction that was actually waste, fraud, and abuse reduction rather than getting the administrative classification and the coding correct?

Ms. DEPARLE. I think I understand your question, Mr. Chairman. And as I understand it the methodology of this audit the Inspector General has used has been the same for the last 3 years.

Chairman THOMAS. But if you'll recall, when we discussed the audit there were a number of categories: Incorrect coding, lack of medical necessity, there were a series of items that were all bundled together to produce the dollar amount, some of which were fraud and abuse?

Ms. DEPARLE. That's right. And the Inspector General has always said there is no way to determine from just this audit how many of these claims were fraudulent. What we do do is we take the claims that they find and we go back after them and some time later you can determine I suppose if there was any true fraud involved. But you're right, the categories that they divided into are: Documentation, medical necessity, coding.

Chairman THOMAS. Non-covered incorrect?

Ms. DEPARLE. Yes, Sir.

Chairman THOMAS. Now, there's nothing wrong with saying we've made great strides in putting the piece of paper in the right bin because that needs to be done, but I think the impression is sometimes left that that means that that significant reduction, i.e., putting the right paper in the right bin, was in fact reduction of fraud and abuse. I guess I would have a little higher comfort level if the report didn't come out 2 days prior to the hearing.

Ms. DEPARLE. Well, the Inspector General—my audit is due to the Office of Management and Budget under the Chief Financial Officer's Act on March 1 of this year. And the reason why they made it available is because they have to give it to Ernst and Young who actually puts together the audit. And the Inspector General said they had to give it to them by the middle of the month. So I think that's why they did it.

Chairman THOMAS. But there's more material that usually comes out on the March 1 date, isn't there?

Ms. DEPARLE. Yes, there's an entire audit and it talks about things like our accounts payable, our accounts receivable, where we've had problems in the past.

Chairman THOMAS. Electronic data processing?

Ms. DEPARLE. Exactly, exactly. And that will all be available, well, we give it to OMB I think on March 1. And then it will be available to the Congress shortly thereafter.

Chairman THOMAS. And my assumption of course is that all of the other parts of that report will be as rosy and the reduction of what other people are calling fraud and abuse?

Ms. DEPARLE. Well, I don't know anything about it yet, but I do know that last year we made progress in achieving a qualified opinion. The year before, the auditors had said they could not render an opinion about our books. Last year they said qualified opinion. My goal is to get a clean opinion. I don't know whether I'll achieve that this year or not. I suspect I won't because there are problems with our accounts receivable at the contractors. But, you know, I'm always optimistic, as you might imagine, in this job.

Chairman THOMAS. One of the difficulties on the Medicare Commission is that we're trying to come up with as many useful measuring devices as possible. One of the things we did in BBA 1997 was ask for a number of tools. One that came across a discussion some time ago was the definition of "homebound." That was something that was due out of your shop by——

Ms. DEPARLE. October 1998.

Chairman THOMAS. October 1, 1998. Where are we on that? I've discovered now that it really is something I would find useful if we could get it?

Ms. DEPARLE. HCFA completed its draft of the report in December, and we have been working to get coordinated with the rest of the department. This is a report, Mr. Chairman, from the Secretary. So we did the initial draft and we're working with the other agencies within the department to get a clearance on that report. And also we will then need to work with the Office of Management and Budget. But we're close to having it finished.

Chairman THOMAS. What does that mean?

Ms. DEPARLE. That I've personally held meetings to try to get things worked out, and I believe that I'll be able to get it up here within a couple of months I hope.

Chairman THOMAS. So it will be after we have to make a report from the Medicare Commission, OK. Some of those tools would be very, very helpful and we thought from the time line that the statute they required be available?

Ms. DEPARLE. Yes, Sir. I don't want to excuse it because you know I take the deadlines very seriously in the Balanced Budget Act. The people who are working on the homebound report are the same staff who have been working on all the other home health changes.

Chairman THOMAS. I understand.

Ms. DEPARLE. And they got it done, but they didn't turn it in until December. And so it's now been going through a clearance process. And knowing of your interest, perhaps I can move it a little faster.

Chairman THOMAS. Well, and knowing we did send you a legislative second bite of the apple on home health care.

Ms. DEPARLE. You did and I appreciated it.

Chairman THOMAS. The gentleman from California?

Mr. STARK. Just a couple of questions on your budget request. I notice that you have already been up to see Mr. Porter, and you're asking for a 3.6-percent increase, is that right?

Ms. DEPARLE. Yes, Sir, that's right, not including the year 2000 funding for the computer systems.

Mr. STARK. One of the things I'm concerned about is that part of your program includes some user fees as a revenue source. What happens if the user fees aren't enacted?

Chairman THOMAS. Can the gentleman yield briefly?

Mr. STARK. Yes.

Chairman THOMAS. Apparently we have 3 minutes on a vote on the floor of the House. And so if the gentleman——

Mr. STARK. I would reserve the balance of my questions.

Chairman THOMAS. Actually, they'll be available just as soon as we get back. The Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. The Subcommittee will reconvene. The gentleman from California, the Ranking Member, is recognized.

Mr. STARK. Mr. Chairman, I am concerned about two things in HCFA's appropriations request. One is that there is some revenue there from user fees which Congress possibly won't enact. I wonder what would happen in that situation? Could you comment on a statement I make when I give speeches? I've always said that HCFA's budget, or Medicare's overhead, was under 3 percent. I don't know if that's accurate. So, what is the correct percentage and if you got your full funding, what would it be?

Ms. DEPARLE. The last time I looked at this calculation, our administrative budget was somewhere less than 2 percent I think of our—of the dollars we spend on behalf of the taxpayers and the beneficiaries. And I don't believe this budget or even the last one which was, as I said, quite a substantial increase from what we've gotten in the past and we really appreciate it, would really change that calculation much.

You ask about the user fees and I've had——

Mr. STARK. I'm not sure that continues to be a hallmark. Maybe it ought to get to 3 percent, but——

Ms. DEPARLE. No, I think that—you and I have talked about this, Mr. Stark. And I think that what the President has asked me to do and what you all have asked me to do is make the most out of the dollars we have and to be as efficient as we can. And I believe we are doing that. I think certainly most private insurance companies operate with higher overhead. But having said that, as I said, last year we did receive a lot of support from the Congress and we hope to work with you this year.

On the user fees, I've had deep philosophical discussions with some of you about the pros and cons of user fees, and I understand there are a number of different views on it. I think I can make the case why these are modest, why given the things we have to do, that it makes some sense to charge $100 for a provider coming into the program so that we can check them out, do a site visit, that sort of thing. But having said that, I know they're not necessarily the most popular up here and I'll be working with all of you again on what to do if they're not enacted. But we hope you'll see fit to look at them and enact them.

Mr. STARK. Thank you. You mentioned that the President has some proposals to protect beneficiaries from disruption of managed care plan withdrawals. Do you suggest that beneficiaries need earlier notification of plans leaving the program, becoming unavailable, or closing? Do they need broader access to supplemental or Medigap policies if they're forced to return to fee-for-service? Now, that only sounds like a bill that I just introduced, but can you elaborate at all as to what you're going to be asking us for? I think it's on page 17 of your written statement. What do you all have in mind?

Ms. DEPARLE. I'd be happy to. Starting——

Mr. STARK. Unless you just want my bill, that would be all right too.

Ms. DEPARLE. I haven't studied your bill, but I did look at a summary of it and it does seem that some of the ideas are the same. We started today by providing the plans with more information and clarification of some of the things that had been in the regulation last year with this mini-rule that we put out today. We're also asking on the plan side for some changes that we hope will make the system go smoother next year, as you noted, changing the submission deadline for the ACRs to July 1, which we think makes more sense both from the standpoint of the plans and giving them more information about the market and also from the standpoint of running our beneficiary education campaign. We are phasing in risk adjustment, which is part of the Balanced Budget Act. We're phasing that in so as to promote stability in the marketplace. We want to do some things to reduce administrative burdens on plans. And, as I said, the mini-rule that we're putting out today, we're publishing today, should help with that as well. We're asking for some reforms that would allow the expansion of Medigap protections for disabled and ESRD beneficiaries that would allow beneficiaries who are affected by plan termination and service area reductions access to all Medigap plans. And we want to work with you all on that.

We would like a one time special open enrollment period for beneficiaries who didn't have a Medicare Plus Choice option. After the plan terminations last year, there were about 50,000 beneficiaries who were left without a choice and for some of them, some insurance carriers didn't properly answer inquiries and some of them got left out in the cold, and we want to make sure they're given some more rights.

Mr. MCDERMOTT. Mr. Chairman? Mr. Chairman? Could I have a clarification on what Ms. DeParle said? You said that people who were out of plans can get into the Medigap, into all Medigap policies at the same premium they had before or can that be changed?

Ms. DEPARLE. I believe it's just access. Right now——

Mr. MCDERMOTT. Just access?

Ms. DEPARLE [continuing]. The Balanced Budget Act made an improvement, as you know.

Mr. MCDERMOTT. But they can be underwritten?

Mr. STARK. I believe they prohibit pre-existing conditions but if you're older, you pay more.

Ms. DEPARLE. That's right.

Mr. STARK. In other words, if it's an age-related premium and you had it at 70 and you want to get it back and you're 75, you have to pay the 75-year-old premium.

Chairman THOMAS. The law says that within 1 year, you can go back and there is no pre-existing requirement. However, in this situation, and the gentleman from California is correct, they could charge a different price, but it cannot be on physical pre-existing condition. It would be age-related.

Ms. DEPARLE. That's my understanding. And what we're doing is, the Balanced Budget Act made an improvement here for beneficiaries but, given what happened last year, we would like to go further and extend further protections.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. STARK. Thank you very much.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. Ms. DeParle, last summer I guess when you were before this Subcommittee, I talked with you about the hospital wage index and how it was weighted toward certain regions of the country and it didn't seem fair. And you agreed and you said that you all were going to undertake a revision of the formula. And in an effort to help you to get the data for that, I think the American Hospital Association put together an effort to do a couple of things: No. 1, provide HCFA with the data necessary to reformulate that wage index; and, No. 2, in the interim, their group, their task force that they formed, came up with an interim formula, if you will, to serve as a change for the index while you were gathering the data, are you familiar with that? And what are your plans to utilize the efforts of that task force and their product?

Ms. DEPARLE. Mr. McCrery, sitting here, I don't have the latest on that. I need to talk to Dr. Berenson and his staff about what they've done. I would like to get back to you on that.

Mr. MCCRERY. OK. If what I've told you is correct, and the industry has gotten together and agreed on an interim formula to tie you over until you get the data that you need to reformulate the index on your own, would you be inclined to use that industry agreement as long as it's revenue neutral?

Ms. DEPARLE. Well, what I would want to do is, obviously the industry's analysis is something that I would want to look at. And I will talk to Dr. Berenson and I'll look at it as soon as I can. What I would want to do is work with all of you to make sure that it is what Congress intended. I would also need to work with our lawyers to be sure that they think I have the authority to do that. But, yes, Sir, I would be happy to take a look at it.

Mr. MCCRERY. OK. With respect to the Y2K problems, you did talk about that in your testimony. And I just want to get some more assurance from you that this is not going to cause a problem to beneficiaries. After all, we've been told before that HCFA is working on computer problems only to find out that the work didn't really produce any good results. Specifically, the Medicare Transaction System that we were told was going to solve all the problems and $50 million later, it didn't amount to much. Can you give us some further assurances that computer problems are not going to cause beneficiaries to go wanting after the year 2000?

Ms. DEPARLE. Yes, Sir, I can. And let me be clear. The Y2K problem is not a computer software problem or design of an infrastructure problem like the Medicare Transaction System was. And I understand and I regret that we all had a bad experience with that. The Y2K problem is a management problem. And it has been the No. 1 priority that I've had at the agency. I wouldn't say that I came to the Health Care Financing Administration to work on it, but I had no choice and we've really put all of our resources and efforts on it.

We also, thanks to the recommendations of the General Accounting Office when I first got there—we've done a number of things to make sure that we have the proper oversight in place, including hiring outside independent experts to come in and look over our shoulders and over the shoulders of our contractors as they make the changes. And that gives me more assurance, and I think it should give you more assurance.

And I would also like to ask the Members of the Committee to help me, as you have in other areas. I've sent a letter out to all 1.6 million providers that we deal with telling them what they need to be doing to get Y2K compliant. I am convinced that we're going to be ready to pay their claims, but we need your help in making sure that the providers are making the changes that they need to make to be able to submit claims to us first of all. And, second, of course to be able to provide services to all of our friends who may be in the hospitals or needing health care around that time. If we can do anything in your districts to provide more information to your health care providers, to your doctors or hospitals, I hope you'll let me know.

Mr. MCCRERY. OK. Thank you. On the hospital wage index question, would you get back to me when you discover more information on that?

Ms. DEPARLE. I will call you tomorrow.

Mr. MCCRERY. Let me know what that's doing?

Ms. DEPARLE. Yes, Sir.

Mr. MCCRERY. Thank you.

Chairman THOMAS. The gentleman from Wisconsin wish to inquire?

Mr. KLECZKA. Administrator DeParle, I have a couple of concerns. The first involves the improper payments. The audit indicates that there has been a significant decrease in actual improper payments. My question to you is what percentage are you at now of total program cost versus improper payments? Are we down to 7 percent I think?

Ms. DEPARLE. Seven point one percent I believe, Sir.

Mr. KLECZKA. Is there a health insurance industry standard for errors in billing and things of that nature? Is there a norm we can compare that to?

Ms. DEPARLE. No, in fact, it's sort of interesting. This is a rather esoteric area, as you might imagine. There's a few people who have done work in this area, one is Professor Malcolm Sparrow at Harvard. And what he says is that, in fact, that Medicare is ahead of the rest of the industry in that we at least measure it and say what it is and then publicly go about attacking it. And that's consistent with the experience I've had. And I've been working a lot with the private health insurance industry, and they've told me that our efforts here have helped them a lot. In fact, they're working with us now on some of these things.

Mr. KLECZKA. Ultimately you're responsible for the entire $12.6 billion in overpayments. However, the amazing part is that the bulk of it is out of your hands; it's the responsibility of the contractors you select. In selecting new contractors or renewing contracts, is their error in billing a factor in that decisionmaking?

Ms. DEPARLE. Yes, it is. And, in fact, one of the things that we did over the past year is we're moving to strengthen our contractor oversight. You're right that it's not in our hands. A lot of people don't understand that we don't actually pay the claims in Baltimore. This happens all over the country with these 77 contractors. But we do have an obligation to oversee them and we're strengthening our oversight of them and that includes looking at their error rate and looking at how they're doing here as part of selecting contractors to do business.

Mr. KLECZKA. How many contractors do you employ nationwide?

Ms. DEPARLE. The ones that process claims, I believe it's 77 or 80. Something like that.

Mr. KLECZKA. OK. And for all 80, you know what their error rate is? You have a pretty good fix on it?

Ms. DEPARLE. I don't know what their error rate is sitting here, Sir, no.

Mr. KLECZKA. No, not off the top of your head, but you do have some record of that back in the office?

Ms. DEPARLE. We probably don't have it on an individual contractor basis. I have asked for that and we've talked to the Inspector General about doing that. To do that, would be very expensive and the sample would have to be much larger because what they do right now is a statistical sample; and they pick 600 beneficiaries and then look at all their claims. And I think it would be valid maybe for some contractors, but not for all of them.

Mr. KLECZKA. But if that's part of the criteria you use to select a contractor or renew a contract, I would think it would be important that you have a little better fix on what the error rate is per contractor. For the bad actors, when renewal time comes, or when they're vying for a contract in another region, that deficiency might be enough to doom their request. Let's give that some further thought.

Do you still think we need some contractor reform legislation?

Ms. DEPARLE. Yes, I do.

Mr. KLECZKA. And what would that consist of?

Ms. DEPARLE. Well, the Medicare contractors by statute, by the 1965 statute, are treated differently than any other government contractors. And I believe that it's in the government's interest and Congress' interest for us to have more flexibility with who we contract with. Some of our contractors do a very good job. With others it's been difficult, frankly, to improve their performance. An example is on Y2K. We've come a long way over the last year, but when we started out the GAO recommended to me that I have a contract amendment to each of my contracts requiring them to be Y2K compliant. And a lot of them balked at that and told me that I had no right to ask for that. The statute is too narrow and we need more flexibility.

Mr. KLECZKA. OK, you just led into my second question. From what I understand, your agency is mostly prepared for Y2K. Where are you and the contractors? You did issue the change in the contracts but where are they as far as coming up to the standards? I know with 1.6 million providers, we're definitely going to see some problems there but the contractors are something you control.

Ms. DEPARLE. Well, I hope not and that's what we're working toward. And that was Mr. McCrery's question. We've made a lot of progress. On our internal systems, as you say, for our mission critical systems as of December of this year, we were compliant on Y2K with all of them. On the external systems, we went from 0 last year to 54 of 77 this year. And I'm working on correcting all the others and getting them tested by the end of March.

Mr. KLECZKA. You went from zero to what?

Ms. DEPARLE. To 54 of 77, which is around 70 percent of the external ones are done.

Mr. KLECZKA. OK.

Ms. DEPARLE. And, as I said, this was a tense situation, but I want to thank the contractors for really focusing on this and helping us get the job done this year.

Mr. KLECZKA. So you have about 30 percent more contractors to come up to snuff?

Ms. DEPARLE. That's right.

Mr. KLECZKA. Thank you very much, Mr. Chairman.

Chairman THOMAS. Thank you. It's been noted, or at least indicated to me, that the press corps wishes to have yellow flags issued so they can throw them at us. [Laughter.]

You don't have your tables that you normally have in 1100, so if you'll allow us to get through the hearing. I do hope there is no reporter that is left outside. Any reporter left outside raise your hand? [Laughter.]

Let's just make sure, and I don't mean that facetiously. Who's on the door? Have we got everybody in? Everyone is created equal but some folks write and others don't. [Laughter.]

The gentleman from Texas.

Mr. SAM JOHNSON of Texas. Thank you, Mr. Chairman. Welcome.

Ms. DEPARLE. Thank you.

Mr. SAM JOHNSON of Texas. In your testimony, you say that HCFA has doubled the number of physicians that you have on your staff. How many do you now have? You know twice one two?

Ms. DEPARLE. I know that. And we have about 30. When you asked me this last year, we had about 15.

Mr. SAM JOHNSON of Texas. I know. Are they actively participating?

Ms. DEPARLE. Yes, Sir, they're at the very senior levels of the agency.

Mr. SAM JOHNSON of Texas. And do they have some——

Chairman THOMAS. If the Chair could interrupt, these microphones are very uni-directional, you need to speak directly into it.

Ms. DEPARLE. I'm sorry.

Chairman THOMAS. No, you're fine.

Ms. DEPARLE. I was answering Mr. Johnson's question in saying that we have 30 physicians now working at the agency and we had 15 last year. And this is an area that he and I have talked about in the past.

Mr. SAM JOHNSON of Texas. And they are physicians that have actually practiced medicine?

Ms. DEPARLE. Yes, Sir, they are.

Mr. SAM JOHNSON of Texas. That's great. OK, I want to pursue the question Mr. Kleczka was talking about a little bit. You're requiring all contractors to be certified as Y2K compliant. Do you have oversight in HCFA to pursue that and make sure they are, No. 1? And, No. 2, what happens to contractors that aren't ready? You said they don't have any right—they told you you didn't have any right to ask for that, well, what did you do with the ones that told you that?

Ms. DEPARLE. In the end we worked it out and they all signed a contract amendment. So I have that now.

Mr. SAM JOHNSON of Texas. They did?

Ms. DEPARLE. They did.

Mr. SAM JOHNSON of Texas. Or they were going to be terminated, right?

Ms. DEPARLE. No, I don't——

Mr. SAM JOHNSON of Texas. Would you do that?

Ms. DEPARLE. I don't know what it would have come to. I don't know—the problem is that under the statute that we have, their position legally was that I didn't have any authority, the Secretary didn't have the authority to require that of them because the statute is written very normally. I mean very narrowly. I think I probably could have done that. I'm glad that we didn't have to. They've worked with us. And, as I said, we're making good progress. Your question was, I'm sorry, Sir?

Mr. SAM JOHNSON of Texas. Do you have some oversight and some way of testing them?

Ms. DEPARLE. Yes, Sir. In fact, I would venture to say there's more oversight on this project than there's ever been on anything at HCFA before. There is one person who is in charge of contractor oversight now. And she is, in fact, one of the physicians I was talking about, Dr. Marjorie Kanoff, who worked at a contractor in Massachusetts before she came to HCFA. There is also Dr. Gary Christoph, who I brought in as our chief information officer from Los Alamos, and he is also overseeing that effort. And we have HCFA employees out stationed at the contractors. So especially at the ones I was mentioning before where they're still not compliant, we've had people on the premises checking them and making sure that we know on a day-to-day basis where they are because the problem when I first got there was we weren't sure and all we had was what they were telling us about where they were. And that, given I think what we all recognize as the problem here, wasn't enough. So we have HCFA staff who are out there.

Mr. SAM JOHNSON of Texas. Are all your reimbursements computer-generated?

Ms. DEPARLE. Virtually all of them. I think we may be the most electronic-billing insurance company in the world.

Mr. SAM JOHNSON of Texas. So if you get a regional blackout somewhere, are you capable of writing checks manually?

Ms. DEPARLE. We will be. We're doing right now a contingency plan that we hope to have ready, the final draft of it, sometime this spring. And it will describe plans for doing something like that. Now, I will be honest with you. I don't know that anybody could write checks for 900 million claims. So what we are preparing is what we believe is more likely to happen, which is a short-term small regional, a few States, that kind of thing. If this happened everywhere, we wouldn't be able to do it. We would not be able to process paper claims with the staff that we have.

Mr. SAM JOHNSON of Texas. You indicated 77 contractors. Then you said it might be 77 or 80. And then in answer to a question, you said you lacked 30 percent having it done. Can you clarify that for me, those numbers?

Ms. DEPARLE. Well, the reason I said 77 or 80 is because when I'm talking about mission critical external systems that pay Medicare claims, I know the number is 77. But there may be some overlap, there may be some higher number of contractors that we have. And Mr. Kleczka was asking how many contractors?

Mr. SAM JOHNSON of Texas. I know.

Ms. DEPARLE. So it's 77 mission critical external systems.

Mr. SAM JOHNSON of Texas. OK, let me ask you one more quick question. It's my understanding that you currently have about 70 data centers. Could they be consolidated? In other words, could you more efficiently operate the data centers if there were a smaller number of them?

Ms. DEPARLE. Yes, and I think that's something that we've been looking at. The problem has been that with all those contractors originally there were many different actual computer systems. What we've been trying to move toward is a standard system for Part A claims, a standard system for Part B, a standard system for durable medical equipment. And when that is done, I would think we could consolidate the number of data centers.

Mr. SAM JOHNSON of Texas. With back-ups, of course?

Ms. DEPARLE. Yes, Sir.

Mr. SAM JOHNSON of Texas. OK. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman have off the top of his head any idea where he would locate this centralized? [Laughter.]

Mr. SAM JOHNSON of Texas. Well, Dallas is pretty central.

Chairman THOMAS. Does the gentleman from Georgia wish to inquire?

Mr. LEWIS. Thank you very much, Mr. Chairman. Madam Administrator, thank you for being here.

Ms. DEPARLE. Thank you.

Mr. LEWIS. Why should the Congress be concerned about contracting reform? What problems are we trying to solve? The current contractors seem to think that the system is working pretty well as a current structure and doesn't need to be changed. I would like for you to respond?

Ms. DEPARLE. I would be happy to. As I said, I want to be clear that many of the current contractors are doing a very good job. And we are going to be doing a very good job of overseeing them. So we're going to make sure that we get good value for the taxpayer's dollar. But the authority under which Medicare contractors are hired and the way they operate is different from any other authority for contractors. The rest of the Government operates under what are called the FAR regulations, the Federal Acquisition Regulations, and they provide more flexibility to the Government in competing contracts. The statute right now says that we're limited to dealing with insurance companies for claims processing for Part B, for example. It says on the Part A side, we're limited to dealing with entities nominated by groups of providers. And since 1965, that's been essentially one group.

And I just happen to believe it's in the Government's interest and in the beneficiary's interest to have a broader group and more of a marketplace and more competition for that. And, again, I'm not saying that every single, that if we get contractor reform, which I hope we can work with you to do, that the next year there's going to be a whole new set of contractors. Some of them will be the same. But I will have more leverage. I will have more oversight authority. Even terminating contractors is a difficult thing to do right now even when there are program integrity problems. And I just think that's not in the Government's interest.

Mr. LEWIS. Health Affairs said that many of your problems stem from funding, flexibility to accomplish your tasks. Is that correct? What do you need from Congress to be able to successfully manage your agency and accomplish your tasks and fulfill the challenges that you're facing?

Ms. DEPARLE. Thank you. One of the things that I need from Congress are hearings like this one today and the interest that this Committee has shown in helping us to improve our management capacity. Resources are scarce, and I understand that, across the Government, but the programs that we're running are very, very important and I appreciate that this Committee recognizes that and has tried to help us to get the resources we need to do our job.

I also think that we need some more management flexibility. Again, this Committee has tried to give us some of those authorities in terms of being able to do competitive bidding for some of the things that Medicare does. There's no reason why Medicare should pay so much more than the Veterans' Administration does for certain products for its beneficiaries. So there are things like that that we can work together on, and I would like to work with the Congress and with this Committee to get those things done.

Mr. LEWIS. Will you be so kind to help us understand the rationale for the President's proposal to use 15 percent of the budget surplus for Medicare?

Ms. DEPARLE. Yes, I think what the President has in mind is ensuring the solvency of the trust fund through 2020. And I believe that he has made this proposal to the Congress as a way of ensuring that the health care of our Medicare beneficiaries, like our Social Security beneficiaries, comes first in the debate that's going to follow about how we handle the surplus.

Mr. LEWIS. Thank you very much. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Does the gentleman from Minnesota wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Administrator DeParle, as a new Member of the Subcommittee, I have more questions than the time will allow. So I assume, Mr. Chairman, that I can submit them for the record in writing and there will be written responses?

Chairman THOMAS. You certainly can and I think you'll find, and I want to thank the gentleman for his attendance today, that we have enough of these that this isn't a one time shot. This is an ongoing road show.

Mr. RAMSTAD. The most pressing question I have, and I ask it as somewhat of a follow-up to Mr. Lewis' question, I think you know Blue Cross/Blue Shield of Minnesota recently notified HCFA that it will end its participation as an intermediary for Medicare Part A. I know this also happened in Illinois last year. In addition, in 1995 in Minnesota, HCFA awarded Medicare Part B administration to United Health Care over the previous administrator, Blue Cross/Blue Shield. Again, as a follow-up to Mr. Lewis, I was wondering if you could clarify how a new contractor for Medicare Part A is chosen? And I ask this because I want to make sure that no Minnesota beneficiary, or for that matter, provider, is harmed by this switch?

Ms. DEPARLE. Well, we look at a number of factors. I can name off some of them and this does happen with some frequency, that contractors come and go. One of the examples you cited was from a program integrity problem, in fact. And what we do is we look at their record for program integrity, meaning have they paid claims appropriately, are there problems there? We look at, wherever we can, we try to make sure that the jobs can be maintained in the place that they were. And we have a pretty good track record there as well. And we look at how it will affect the providers because if providers have to change from one system to another, I've described before that the contractors use different computer systems. So if we were changing the Minnesota providers over to another system, another contractor, it would be in their best interest if it could be the same computer system so they wouldn't have to make changes to their computer system. So we look at things like that.

Also, I must make clear that under current law, the Blue Cross and Blue Shield Association chooses replacements for Part A contractors known as fiscal intermediaries, not HCFA, and that is one of the things we propose to change with contracting reform legislation.

Mr. RAMSTAD. I appreciate that response. Let me shift to a different area, Administrator DeParle. I know that HCFA's rules delineate the criteria for determining whether a reimbursement level is grossly excessive or grossly deficient. Yet the DMERC notices on inherent reasonableness do not reference any of these criteria. I would like to know what criteria were used to determine that the payment levels were inherently unreasonable?

Ms. DEPARLE. I believe, Mr. Ramstad, you're referring to the notices that were put out some time in the fall under the inherent reasonableness authority that the Congress gave us. And what we were looking at—there are items of durable medical equipment and we did do analyses. The DMERC medical directors did do analyses. And what I recall about it is they looked particularly at what the Veterans' Administration is paying, and in some cases we were paying two to three times what the Veterans' Administration was paying for certain items of durable medical equipment. I would be happy to provide you with a briefing on the analyses behind that.

Mr. RAMSTAD. That I would appreciate, thank you. Let me ask finally I know under current law the Medicare Plus Choice plans are paying for most of the beneficiary education programs even though the health plans currently enroll, as I understand it, only about 15 percent of Medicare beneficiaries. It's been suggested to me by a number of people in Minnesota that the fee-for-service Medicare should contribute to the user fee since it's also one of the choices. Can you respond?

Ms. DEPARLE. Well, this is an area that the Committee and the Committee staff have paid a lot of attention to. What we tried to do with the $95 million is make sure that we used it only as the statute said. In the handbook, for example, if we were providing information that is more about fee-for-service Medicare or general Medicare that was not part of what the Congress talked about in this education campaign, we funded that out of our regular program management budget because I wanted to be sensitive to what you all intended with the user fees. And I understand the health plans' position on the user fees. I've met with a number of them and I understand how they feel and we're open to working with the Congress on what you think is equitable here.

Mr. RAMSTAD. Thank you, Administrator. Mr. Chairman, I yield back.

Chairman THOMAS. Thank the gentleman. The gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Thank you, Mr. Chairman. Administrator DeParle, thank you for being here. This is my first time on this Committee, so I don't have some of the advantages of some of the work has done. However, as was maybe mentioned in the opening, I probably do have a lot of Medicare and more than most on this Committee. And one of the issues hitting Florida, and quite frankly hitting all across the country, has been the issue of HMOs pulling out and leaving hundreds of thousands of people without any care. I know that you've recently done some information on the Internet, which I thank you for. It's been a great help. Can you give us some ideas of some other things that might be taking place over the next couple of months that will help these people who have lost this care?

Ms. DEPARLE. Well, as I mentioned, we want to work with the Committee on some proposals that we've come up with to try to help the people who were affected this year; and also to provide more of a safety net for folks next year in case there are more plan withdrawals. Florida was particularly heavily hit on this, and we did something like a thousand meetings around the country sitting down one-on-one with beneficiaries in townhall meetings to try to help them work through this. We want to have a more concerted campaign next year so that they know where to go for information and help.

It is interesting in looking at the pattern around the country, we've been analyzing this some, and there are some parallels to what happened in the Federal Employees Health Benefit Plan. In fact, in some counties, it was precisely the same counties where they pulled out, and in that program it's interesting I think there was a 5-percent increase last year. So we're trying to analyze exactly what happened, and we're doing what we can to work with the plans to minimize disruption next year. One of the things we want to do is change the deadline for the submission of ACRs, the Adjusted Community Rate documents, which we hope will give the plans more time to fully assess the market and know where they intend to be because it is extremely damaging to beneficiaries to hear at the last minute that their plan isn't going to be there. So we want to work with you to try to make improvements.

Mrs. THURMAN. I appreciate that because they really are very concerned. For most of them, it's the pharmaceutical assistance but it really has put them in a feeling of just being left out. So they're very concerned about it.

I know that on the MSNs we've cleared that up, and I appreciate the help you gave on this because we started to hear from our folks at home. On the other side of that though, it really won't go into effect until July of this year. Are there some other places where our patients can get this information before it actually is reinstated so that they would have that available to themselves?

Ms. DEPARLE. There are and I want to say that I appreciate your bringing this problem to my attention because I hadn't been aware of it. What Mrs. Thurman is talking about is that some beneficiaries were not getting the explanations of Medicare benefits, or Medicare summary notices, because of a change that had been made last year to suspend them in certain cases. If there's a beneficiary who wants one and they're not getting them yet because it hasn't been phased in—we expect to have them all in by July—they can call the carrier or intermediary that's in this document that all the beneficiaries got last year. They either got the handbook, if they were in Florida, or they got this bulletin that gives the number for their intermediary or carrier. If they call there, they can get a copy of their Medicare summary notice.

Mrs. THURMAN. Let me follow-up with that then because at any time that we do legislation there's unintended consequences that maybe wasn't thought all the way through or as rules go and change. As you've gone through in implementing these, you said you've been through like 188 of them. You have 300 of them to do. And we're starting to hear from these constituents who have now been placed under these rules. And there are some that I don't think we thought was going to happen, and I think, Mr. Chairman, you talked about one with the homebound. We've got an awful problem with people with disabilities that are not getting the home health care and don't really fall under the homebound that may end up going into nursing care homes when they're perfectly capable of staying home. But are there some other areas that we have gotten some unintended consequences that we need to be aware of or that we can be helping work on over this next year?

Ms. DEPARLE. Well, one of them is one that we've been discussing a little bit this afternoon, which is some of the filing dates in the Balanced Budget Act. And I don't think when we were working on that, anyone thought about the impact that a May filing date might have on plans, for example. And that was a domino effect on beneficiaries later on. So there are things like that that I think we can work together to fix.

There were things in the regulation that we put out that we didn't realize were going to be difficult for plans to meet. And, as I said, today we issued a regulation to try to deal with those things. Some of them we can deal with administratively. Some of them we'll need your help on. Certainly in areas like home health, we've been monitoring that very closely around the country to sort of see what the patterns are.

I was very concerned about were there going to be increases in nursing home admissions? And so far we're not seeing that. But we want to continue to work with the Committee and identify those areas as quickly as we can. And then if we need to address them, we'll do whatever we can to work with you to get that done.

Mrs. THURMAN. Thank you.

Chairman THOMAS. Thank the gentlewoman for her questions. The gentleman from Maryland is no longer a Member of the Committee. His ticket has expired. Apparently he went for power such as it is within the minority side to become Ranking Member on another Subcommittee. [Laughter.]

Mr. CARDIN. I was just following the term limits I thought that was in the rules package from the—— [Laughter.]

Chairman THOMAS. Unfortunately, that's on our side of the aisle and not yours. But I do appreciate his commitment to me personally that he will stay with us on the major issues. His knowledge and background is invaluable. You were not here when I passed out the penalty flags, so you can have an honorary one. The idea is instead of us talking over each other, we're just going to throw penalty flags at each other. And no one has thrown one today. So I'll be the first to throw it. [Laughter.]

Mr. CARDIN. Well, Mr. Chairman, let me thank you——

Chairman THOMAS. Let the Chair first of all say that if we had these over the last several Congresses, the gentleman from Maryland would never have gotten one. [Laughter.]

Mr. CARDIN. Now he says that. When I was on the Committee—— [Laughter.]

Chairman THOMAS. I don't need your vote any more. [Laughter.]

Mr. CARDIN. Well, I'll take this and I might use it from the audience. Let me first thank you for the courtesy.

Chairman THOMAS. I'll tell the gentleman I've already told that reporters don't get any. [Laughter.]

Mr. CARDIN. Oh. I might trade this for a vote from the Committee. But first let me thank you for the courtesy of allowing us to participate in this hearing and subsequent hearings. The work of this Subcommittee is very important to all of us and I very much appreciate that.

If I might, I just really wanted to ask the administrator, following up really on Mrs. Thurman's questions on outreach to our constituents. Our health care system is very complicated. It's difficult for seniors to understand what's covered and what's not covered. The President in his initiative on long-term care is suggesting more resources to HCFA in order to assist seniors in understanding what their options are to cover long-term care. With Medicare Plus Choice and many HMOs pulling out of the market, my State had I think the fifth largest number of dis-enrollees in HMOs and our telephone lines were ringing off the hook, so I can imagine what was happening at HCFA at the time. You have established a 1–800 hotline in I think five States. Maryland is not one of those States that had those services.

My question to you is do you have adequate resources in order to help our seniors understand the complexities of our system, whether it's Medicare Plus Choice or whether it's long-term care or whether it's prescription drugs, we're all getting questions about that. Do you have the capacity to help us in getting the information out to our seniors as to what the law is, what their options are, and how they can best cover their own health care needs?

Ms. DEPARLE. Well, that's a very good question, Mr. Cardin. And I would say this. We're trying to build something new here. And we started from the ground up and it's not going to be perfect overnight. And it was a shame that last year the disruptions in the market occurred at the same time that we're trying to run this new beneficiary education campaign.

Having said that, in the five States where we did the initial work—we piloted it last year—we've done focus groups, and I think the Committee will be glad to know that in general beneficiaries liked the information. I think something like 80 percent of them said they saved the handbook because they thought it was going to be useful as a reference tool. So over time, I think that we're going to see that that makes a big difference, that this campaign, which is not just a handbook and not just a toll free line, but is a whole system really, is going to make a difference. And I hope that part of that will be educating people on long-term care because that's something many of them don't begin planning until it's almost too late. And we are asking for resources to do that.

As far as whether we have enough, we have asked for more resources. We did last year as well, and that was the one area of our budget that we were not successful in. And we want to work with the Committee to make sure you understand what we're trying to do and to seek your support for more resources to do a better job on the beneficiary education campaign.

It's clear to me that while beneficiaries like the handbook and they like the toll free lines, and by the way we are expanding that nationwide over the next 6 to 8 months, a lot of them want individual contact. We can't do that. Many of your States, you should know, should be complimented because the insurance commissioners, I met with this weekend, and the insurance commissioners in your States have been active in trying to help us with this as have the agencies on aging and those networks and the State insurance counseling programs. We need to put all of this together to make this work for our beneficiaries. And I believe we can do it, but it's going to take more work on both of our parts. And I'm eager to work with you on it.

Mr. CARDIN. I appreciate that and I hope that we'll continue to work on it. Just one last point, to underscore again what Mrs. Thurman said about the rationale of HMO pull-out and that in some regions in our State, which are the so-called low-cost areas, beneficiaries don't understand why they have to pay more money for an HMO to get coverage than someone who enrolls in a high-cost area. So it doesn't seem to make a lot of sense, and I think we need to re-think how Medicare Plus Choice should operate to guarantee citizens of a State equal access to the variety of options that are out there. And we look forward to working with you on that particular issue.

Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The gentlewoman from Connecticut wish to inquire?

Mrs. JOHNSON of Connecticut. Thank you very much, Mr. Chairman. First of all, let me say welcome and I appreciate the tremendous workload that you have shouldered since you've become head of HCFA; and feel that the American people should be grateful for your intelligence and capabilities. I thank you.

Ms. DEPARLE. Thank you.

Mrs. JOHNSON of Connecticut. I also want to dissent from a word that my friend used earlier, Mr. Stark, "overwhelmed." I've never seen anyone carry such a load and not be overwhelmed. I appreciate not only what you've accomplished but also your endless openness to those of us who are out in the field to the problems that we see and to allowing them to have an effect in your department and the work that you're doing. So I think that's very helpful for all of us.

I have three questions I want to try to get through and I know I have very little time. So let me just try to at least lay them all on the table with one other comment before that. I was very interested to read that the managed care plans are going to pay for the costs of clinical trials. And I think we need to at least do a demonstration project in Medicare so that we can find out whether this is going to raise our costs or lower our costs. I believe it will lower our costs. So I think we're being held back by a false estimate. Maybe we could work out some way to find out the truth in that matter before seniors are the only portion of the population not allowed to benefit.

Ms. DEPARLE. Well, as you know, I want to do that too. And we have a proposal and want to work with you on it.

Mrs. JOHNSON of Connecticut. Good. In the budget, in the President's budget, there is a proposal to require all private insurance companies to provide Medicare second payer information to help HCFA coordinate benefits when Medicare is the secondary payer. It seems to me that this will be extraordinarily difficult for you to get in place, just the information management technology and the coordination with the private sector. Is this going to be possible to do this year?

Ms. DEPARLE. I believe that that proposal would take effect some time in the spring after we've already accomplished our Y2K changes that we need to make.

Mrs. JOHNSON of Connecticut. Well, they have no effective date. It does, however, have a $650 million fiscal impact, apparently over 5 years. So I wonder if we are going to be able to actually make the changes required to get that kind of money when we aren't even going to be able to do the updates this year?

Ms. DEPARLE. For this year, I think for Fiscal Year 2000, the actuary is estimated only about $10 million in savings from it and that's why we wouldn't be able to begin implementing that until after we finish all the Y2K changes that need to be made. And then I have an agenda of getting the home health prospective payment system done, out-patient, and all the other things that are in the queue. So I believe that these estimates are reasonable, but it is true that we won't be able to do it right away.

Mrs. JOHNSON of Connecticut. Thank you. I also wanted to know if you still needed contractor reform legislation? As I think you are now aware, we've had terrible problems with a contractor in Connecticut. And, in fact, the hospitals are months behind in their Medicare reimbursements. And for institutions now that are under tremendous pressure, especially the small hospitals, this is a really serious situation. Do you still need contractor reform legislation and what kind of changes are you looking for?

Ms. DEPARLE. Yes, I think we do need contractor reform legislation. And I want to thank you for bringing to my attention the problems up in Connecticut and urge other members to do the same thing when you're having problems because sometimes we don't hear about them unless you let us know. As I've said to other members who have asked about this, I think the Government needs more flexibility. We need a more competitive environment. We should not be limited to dealing with a set group of insurance companies or other entities. And I think that that part of the statute has been pretty much the same since 1965 while other Government contracting authorities have been reformed and revised to give the Government more flexibility and, frankly, a better price, more competition. So I look forward to working with the Committee on coming up with some sort of equitable solution to this problem.

Mrs. JOHNSON of Connecticut. OK. And then let me just get on the table a very serious problem that is looming for the nursing homes. It's particularly, again, a particularly difficult problem for small nursing homes and that is the issue of medically complex patients. I am absolutely focused on dealing with the problem of nursing homes not being able to handle what we are not requiring them to handle or at least they think we're requiring them to handle in the way of transportation costs, ambulance costs, and prosthetic device costs. But a separate and very important problem is the issue of the medically complex patient. Things are changing so rapidly that there are hospitals re-categorizing beds so that they don't have to accept these patients because they can't afford to care for them. This would back them up into our small hospitals and finally have a terrible effect on the system.

What are you doing, or are you doing anything, to develop an interim solution? Ultimately the PPS system hopefully will deal with this fairly but in between now and then, we really have problems.

Ms. DEPARLE. Well, as you know, Mrs. Johnson, we implemented the skilled nursing facility prospective payment system last year on schedule. And one of the components of it are these resource utilization groups that attempt to capture the cost of providing care to different types of patients. The issue I think you're referring to is whether or not those, the RUGs system captures the acuity of patients. And we have spent a lot of time with many nursing facilities around the country talking about this, and, in fact, we've already contracted with Abt Associates to develop some better measures so that we can fine-tune the payments for more acutely ill patients. And we're working on that as quickly as we can.

Mrs. JOHNSON of Connecticut. I would like to work with you further on this because those RUGs are based on 1995 data. And the treatments that nursing homes are carrying out now 3 years later are just very different and that old data really doesn't capture the kinds of patients that many of the nursing homes are dealing with now. So we have a disconnect, but it's serious enough that if a small home has a couple of bad experiences, they could be financially at risk. So I appreciate the opportunity to work with you on it.

Ms. DEPARLE. Thank you.

Mrs. JOHNSON of Connecticut. Thank you, Mr. Chairman.

Chairman THOMAS. Just to follow-up on that, I suppose it's a cardinal sin for us to say that we would welcome all of those complaints and concerns because that's our job to resolve them. But one of the things that I think would be very, very helpful is if you could indicate to us a willingness and a desire to, for want of a better term, maybe have a townhall meeting to get these folks in. Clearly, a procedure to sophisticate the RUG, some mitosis process to produce the sub-RUGS that grow up to be RUGs fairly quickly. I guess throw mats become area RUGs or whatever. [Laughter.]

The appropriate analogy would be. It doesn't make a lot of sense to have them go through us. We hold you in a hearing. This stuff has to move fairly quickly and if you would indicate that it might be possible that you could have some open meetings for these folks to indicate their concern and then you could reflect back to them directly, that seems to me something that would be worthwhile. What's your comment on that?

Ms. DEPARLE. Yes, I think so. That's something we've been doing, in fact, successfully on some other issues, and we would be happy to host a townhall meeting, either in Washington or Baltimore, to get as many of those folks in to make sure we understand the problem.

Chairman THOMAS. And let me end on this. One of the charges of the Medicare Reform Commission is to deal with solvency. And I've been thinking about this, and join with me in going through this thought process, especially focused on the President's most recent budget. When we say the Medicare Program is solvent, it's in reference to Part A.

Ms. DEPARLE. Yes.

Chairman THOMAS. Which is a payroll tax because Part B was an add-on with physicians and it's the general fund. And the payroll tax was analogous to the Social Security payroll tax. But the HI Trust Fund is now different because in the early nineties, we lifted the lid. It is much more of a progressive tax, notwithstanding that it's on payroll.

And that the old analogy, Greenspan, in front of the Full Committee, said it better than I ever heard anybody say, "These people have holdings which are appreciating at greater than market rates." They get three and four times the amount they paid in. That's still true of early retirees today. But if you project over the period that the Medicare Commission is supposed to be looking at this, those beneficiaries in 2020, 2030, in terms of the amount that they're paying in, with no cap on their income, looks a whole lot more like an income tax, because that's what it is with no cap, but it's a limited, it's a particular category of an income tax.

Then in 1997, to add additional years to the solvency of the HI Trust Fund, we transferred the fastest growing portion of Medicare, home health care, to Part B. Now, if we're still talking about solvency, and you just in response to a question of a member, and the President said, "I can get you out to 2020 if we take general revenue surplus and put it in the HI Trust Fund." I can create an infinite solvency test. Any time you're in trouble, transfer a program from Part A to the general fund or, in fact, do what we all think is appropriate, combine A and B.

And all of these things are happening to the point that if we simply allow current law to affect itself over time, what was 50/50 with the initial switch of home health care becomes 60/40 general fund and will ultimately become 70/30 general fund. I don't know that solvency makes any sense as a test any more, especially with the President's offer to get us to 2020. I can get us to 2626, or whatever that song was, by doing that same sort of thing. It doesn't mean anything any more.

I think maybe, and this is what I've been trying to do, and I would appreciate your reaction, not now, but as we talk over the next several months, I think exposure is a term that's far more useful, exposure of the general fund, because if you still have a payroll tax and it is progressive, you're going to have people who are paying in who are payers, hopefully they become beneficiaries.

So if you take a snapshot in time, you've got payers into the system, you have the beneficiaries, but you have the general fund.

I do think it's a useful dynamic, for those paying in and those who are receiving, to have the ability to negotiate between them what an appropriate rate of payment versus beneficiary reciprocation is. But if you have a general fund that's available at any time to continue to add to it, using the old solvency test, it is the general fund that will be the bag that holds all concerns of both the payers not wanting their rate to go up or the beneficiaries not wanting their benefits to diminish.

So one of the difficulties in the Commission now is how, given this dynamic, do we deal with what is an appropriate substitute for solvency since solvency isn't a problem because you can buy it away? And you buy it away with the general fund, either through a transfer programmatically or simply dumping cash into it. Think about it. Exposure to the general fund I think is something that—how much is the general fund going to carry of this program, notwithstanding the fact that you have payers in the payroll tax and that you have a package of benefits that will change over time, the people who are receiving them?

We haven't talked about this, but I think we need to think about it.

Ms. DEPARLE. I see the issue and I'll be happy to spend some time thinking about it.

Chairman THOMAS. Thank you very much. And thank you once again.

The Committee would now ask—if there are no further questions? Quick one?

Mrs. JOHNSON of Connecticut. I just want to ask one brief question? I notice you've hired a lot of physicians and gerontologists. That's a very good thing. Have you hired anyone who has had experience within managed care?

Ms. DEPARLE. Yes.

Mrs. JOHNSON of Connecticut. Making protocols work, managed care actually work?

Ms. DEPARLE. Yes, in fact, the geriatrician, who's the chief clinical officer for HCFA now, Dr. Jeff Kang, was the medical director of a managed care plan up in Boston. And Dr. Berenson, who is the head of the Center for Health Plans and Providers, ran a PPO, in fact, here on Capitol Hill and so has had that experience as well.

Mrs. JOHNSON of Connecticut. Thank you.

Ms. DEPARLE. I think most of our physicians have had experience in managed care.

Mrs. JOHNSON of Connecticut. Thank you.

Chairman THOMAS. Thank you again.

The Chair would now ask Dr. Scanlon to come forward as the Director of the Health Financing and Public Health Issues, Health Education and Human Services Division of the U.S. General Accounting Office. He has always assisted us in a systematic examination of the operation of HCFA, and we welcome you once again. Your written testimony would be made a part of the record, without objection, and we invite you to inform in any way you see fit. Welcome, doctor.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much, Mr. Chairman, and Members of the Subcommittee. With me today is Leslie Aronovitz who is an Associate Director in the Health Financing and Public Health group at GAO and who has been very heavily involved in our review of HCFA for this hearing today.

In 1996 and 1997, Congress passed the Health Insurance Portability and Accountability Act as well as the Balanced Budget Act to help HCFA combat fraud and abuse and constrain Medicare spending growth. However, implementing these laws added substantially to HCFA's ongoing responsibilities to manage both Medicare and Medicaid.

Last year, you asked us to assess HCFA's capacity for this Subcommittee, because you were concerned that the HCFA was not prepared to shoulder all these responsibilities. Then we reported that the HCFA's tasks appeared to be outstripping its ability to manage its workload. This year, you have asked us again for such an assessment. Today, our message is a bit more complicated. HCFA has made great strides in addressing many of its immediate priorities. These include readying critical computer systems for the year 2000 problem and implementing many provisions of HIPAA and the BBA. But the number and the complexity of BBA requirements and the urgency of the computer system changes, coupled with a backlog of decades-old problems with HCFA's routine operations, make it clear that much more needs to be accomplished. Its capacity, while greater than last year, also needs further strengthening for the agency to successfully fulfill its mission.

The immediacy of the threat, the amount of work, and the resources needed to meet the Y2K challenge, coupled with the Agency's late start, have put a tremendous burden on HCFA this past year. It has pushed hard to catch up, and, as you have heard, it has made considerable progress. The GAO has been monitoring this progress closely, and Joel Willemssen from our Information Resources Issue area is scheduled to provide our assessment at a hearing of the Full Committee on February 24.

Unfortunately, the rush to complete the Y2K renovation affected the timing and quality of the Agency's work on many other projects. For example, this delayed needed computer systems modernization. As a result, the Agency has been forced to spend millions to renovate certain systems for Y2K readiness that it then plans to replace soon after the year 2000. Similarly, HCFA has had to delay the implementation of new prospective payment systems intended to slow program growth for services such as home health and hospital outpatient care.

There has also been less managerial time and attention available to oversee ongoing operations. HCFA's financial management and oversight of Medicare's fee-for-service claims administration contractors are longstanding problems needing more attention as is assurance of the quality of care provided in nursing homes and by home health agencies.

HCFA has made strides in improving the fiscal integrity of the Medicare Program. This year, it promptly distributed the Medicare Integrity Program funds to contractors so that they could work to reduce fraud and abuse. It has developed a strategic plan to better focus its activities for program integrity, but many of these initiatives are just starting.

While there has been progress made in putting in place many of the HIPAA and BBA requirements, we believe that important refinements are still needed. To give you just one example, we are concerned that the design for the new Prospective Payment System for skilled nursing facilities does not fully eliminate payment for unnecessary services and that there is not sufficient oversight planned to ensure that providers do not game the system. In addition, we are aware of the concern that Mrs. Johnson raised in talking with Administrator DeParle about the adequacy of rates for medically complex cases and are, for this Subcommittee, looking into that issue as well.

Compared to last year, HCFA's capacity is greater. Many of the transitional problems of the reorganization are history. Additional staff with needed skills have been hired, and some of the losses due to attrition have abated. On the other hand, in focus groups we conducted, HCFA managers and staff discussed issues that continue to hamper effective agency operations. Some of the communication and decisionmaking difficulties associated with the reorganization still persist.

At times, the Agency's decisionmaking process has been slowed considerably. For example, travel funds were not allocated well into the middle of last fiscal year. Managers also stated that the performance and awards systems do not motivate or hold their staffs accountable for achieving program results.

HCFA still faces the challenges of an aging work force. In fact, almost a quarter of its staff, most with management and technical expertise, will be eligible to retire in the next 5 years.

In conclusion, I would note that HCFA's senior officials have taken concrete steps to improve agency management this year. But the Agency's continuing challenges are taxing. After the dusts settles from Y2K, HCFA will need to overhaul its antiquated computer systems. In addition, it will need to improve its financial management, its oversight of Medicare contractors, and its effort to assure the quality of beneficiary care. Strong leadership and management, more effective planning, acquisition of staff with needed skills, and better accountability are keys to addressing these challenges. A true measure of HCFA's success will be its ability to maintain its current momentum as it enters the 21st century.

Thank you very much, Mr. Chairman. I would be happy to answer any questions you or the Members of the Subcommittee may have.

[The prepared statement follows:]

Statement of William J. Scanlon, Ph.D., Director, Health Financing and Public Health Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss the Health Care Financing Administration's (HCFA) ability to meet its new and growing responsibilities. HCFA pays for health care coverage for nearly a quarter of the population. Two of the programs HCFA administers cost federal and state taxpayers about $370 billion in fiscal year 1998—$193 billion for Medicare and $177 billion for Medicaid—and represent an ever growing proportion of the federal budget—currently about 18 percent. Because of the size and complexity of its programs, we have been reviewing HCFA's operations since the agency was created more than 20 years ago. Over the years, we have reported on problems in HCFA's management that weakened the fiscal integrity of these programs—leading to increased monetary loss from fraud, abuse, and erroneous payments. We have also reported on management problems that have led to poor-quality care provided to vulnerable beneficiaries. In 1990, we developed a list of agencies and programs that were "high risk" because of their vulnerability to waste, fraud, abuse, and mismanagement. We included Medicare on our original list, and it remains on the list to this day.

The long-term financial condition of Medicare is now one of the nation's most pressing problems. Recent legislation gave HCFA substantial new authorities and responsibilities for reforming Medicare in order to extend the solvency of Medicare's Hospital Insurance Trust Fund beyond 2008. This legislation also established the Bipartisan Commission on the Future of Medicare to develop more long-term solutions for further ensuring Medicare's integrity and solvency. Because of your concern about HCFA's preparedness to implement these new authorities and administer its programs, you asked us to review HCFA's management capacity and to testify before this Subcommittee last January. You asked us to report today on our updated assessment of HCFA's progress—focusing on the agency's ability to meet its increasing workload in the short term. Specifically, you asked us to review HCFA's progress in (1) addressing its most immediate priorities and (2) strengthening its internal management to effectively discharge its major implementation and oversight responsibilities.

We relied on our substantial body of past and ongoing work to assess HCFA's performance in meeting its current responsibilities.[1] We supplemented this work by interviewing 28 agency managers and officials, including the Administrator and Deputy Administrator. In addition, we conducted small focus groups attended by 46 senior and midlevel managers and 20 staff, and reviewed agency documents.

In summary, HCFA is facing an unprecedented set of challenges. The Balanced Budget Act of 1997 (BBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were designed, with considerable input from the administration, to strengthen HCFA's ability to prevent fraud and abuse and constrain spending growth in the Medicare program. These laws added substantial new authorities and programmatic responsibilities to HCFA's ongoing management of Medicare and Medicaid. In response to these mandates and program responsibilities, HCFA's accomplishments have been impressive. However, measured against the magnitude of challenges it faces, HCFA's progress seems more modest. The immediacy and resource demands associated with meeting the Year 2000 computer system challenges—coupled with HCFA's late start in addressing them—have put a tremendous burden on the agency this past year and have affected the timing and quality of its work on many other projects. For example, it has delayed needed systems modernization and computer changes that implement new payment systems intended to slow program cost growth. It has also slowed efforts to improve the oversight of ongoing operations, such as financial management and Medicare fee-for-service claims administration, which desperately need attention. Even where HCFA has made progress—such as in implementing a number of the mandated HIPAA and BBA requirements—we believe that more work, and many refinements, are still needed.

HCFA must meet these challenges with an aging workforce. In fact, almost one quarter of its staff—most with managerial and technical experience—will be eligible to retire in the next 5 years. HCFA has taken a number of steps internally to capitalize on its staff's strengths to deal with a rapidly changing health care marketplace and growing responsibilities. For example, HCFA has developed a strategic plan that better articulates its future direction, has progressed in its customer-focused reorganization by moving staff to their new organizational units, and has hired more staff with needed skills. On the other hand, in focus groups we conducted, HCFA managers and staff discussed issues that continue to hamper effective agency operations. For example, HCFA's reorganization slowed the agency's decision-making process so that even travel funds were not allocated until well into the middle of the fiscal year. Managers also stated that the performance and awards systems neither motivate staff nor hold staff accountable for achieving program results.

To further strengthen HCFA's ability to effectively manage its employees and programs, the administration has proposed new authorities for contracting and new

[1] See Related GAO Products at the end of this statement.

flexibility in hiring in the President's budget for fiscal year 2000. It also proposes new mechanisms to enhance agency accountability, with biannual reports to the Congress and an advisory board to help the agency streamline internal and program management. HCFA senior officials have taken concrete steps to improve agency management this year but will need to maintain the momentum over the next several years to overcome the agency's current and future challenges. This will be especially difficult in an agency that for years has been plagued by external pressures and management problems.

BACKGROUND

HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for administering much of the federal government's multibillion-dollar investment in health care—primarily the Medicare and Medicaid programs. Rapid increases in Medicare program costs, coupled with increasing concern about fraud and abuse in the program, led the Congress to enact legislation—HIPAA and the BBA—to strengthen Medicare. HIPAA established the Medicare Integrity Program, which ensures increased funding for Medicare program safeguard efforts and authorizes HCFA to hire specialized antifraud contractors. The BBA made the most significant changes to Medicare in decades, designed to reduce the growth of Medicare spending. The law requires HCFA to implement new payment methodologies, expand managed care options, and strengthen program integrity activities. At the same time, these laws also added entirely new responsibilities—such as oversight of private health insurance and implementation of a new state children's health insurance program—to HCFA's historic mission to administer Medicare and Medicaid.

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion. Most of these beneficiaries receive health care on a fee-for-service basis, in which providers are reimbursed for each covered service they deliver to beneficiaries. HCFA contracts with about 60 insurance companies to process the high volume of fee-for-service claims—numbering about 900 million in fiscal year 1997—submitted by about a million health care providers for payment. Medicare's managed care program, the other principal component, covers the growing number of beneficiaries who have chosen to enroll in prepaid health plans, where a single monthly payment covers any needed services. About 6.8 million people—about 17 percent of all Medicare beneficiaries—were enrolled in more than 450 managed care plans as of December 1, 1998.

Medicaid, a $177 billion federal and state grant-in-aid entitlement program administered by states, finances health care for about 36 million low-income families and blind, disabled, and elderly people. At the state level, Medicaid operates as a health insurance program covering acute-care services for most recipients, financing long-term medical care and social services for elderly and disabled people, and funding programs for people with developmental disabilities and mental illnesses. In addition, the BBA created the state-operated Children's Health Insurance Program, which provides federal grants to states to provide basic health insurance coverage for low-income, uninsured children. Through this program, states have a choice of either expanding their Medicaid programs or developing a separate program to insure children.

Under HIPAA, HCFA also has a completely new responsibility for ensuring that private health insurance plans comply with federal standards. In five states that did not pass legislation conforming to key provisions of HIPAA, HCFA has direct responsibility for enforcing HIPAA standards for individual and group insurance plans. In addition, HIPAA, along with the BBA, provides HCFA more opportunities to improve its fraud and abuse identification and prevention programs in Medicare.

HCFA had about 4,100 staff as of October 1998. About 65 percent were located in the central office and the remainder worked in the agency's 10 regional offices. In addition to its workforce, HCFA oversees Medicare claims administration contractors who employed an estimated 22,000 people in fiscal year 1997.

HCFA HAS MADE SOME PROGRESS ADDRESSING ITS HIGHEST PRIORITIES, BUT MANY PROBLEMS REMAIN

Last year, we told you that substantial program growth and greater responsibilities appeared to be outstripping HCFA's capacity to manage its existing workload. Today, the message is a more complicated one. HCFA has made great strides in addressing many of its immediate priorities—including readying critical computer systems for the year 2000 and implementing many provisions of HIPAA and the BBA. But the number and complexity of the BBA's requirements and the urgency of systems changes, coupled with a backlog of decades-old problems associated with HCFA's routine operations, make it clear that much more needs to be accomplished.

HCFA Made a Concerted Effort on Y2K, but Critical Tasks Are Incomplete

Over the past year, HCFA has made a concerted effort to deal with its most pressing priority—the Year 2000 computer systems problem—commonly referred to as Y2K.[2] If uncorrected, Y2K problems could cause computer systems that run HCFA's programs to shut down or malfunction, resulting in serious disruptions to payments to Medicare providers and services to Medicare beneficiaries. Addressing Y2K is a formidable task for HCFA, because the Medicare program uses 6 standard claims processing systems, about 60 private contractors, and financial institutions nationwide to process about 900 million Medicare claims each year for about 1 million hospitals, physicians, and medical equipment suppliers.

In September 1998, we reported that time was running out for HCFA to modify Medicare systems to handle Y2K.[3] HCFA was severely behind schedule in repairing and testing its systems and in developing contingency plans to handle system failures. Until 1997, HCFA was attempting to develop the Medicare Transaction System—which would be Y2K compliant—to replace its existing Medicare claims processing systems. But the project was halted because of design problems and cost overruns. This left HCFA with multiple, noncompliant Medicare claims processing systems that needed modernization. Compounding this difficult task was HCFA's failure to adequately direct and monitor its Y2K project. We recommended changes to better manage its Y2K efforts, and HCFA agreed to implement our recommendations as soon as possible.

HCFA recently reported to HHS that as of December 31, 1998, it had completed renovating 5 of the 6 standard systems used by its contractors to pay claims and all 25 of its mission-critical internal systems. We are now monitoring HCFA's progress in implementing the recommendations in our September 1998 report, and we are reviewing the agency's progress in addressing the critical areas of Y2K testing and business continuity and contingency planning. We will testify on these issues to the Congress in the next few weeks. Furthermore, although HCFA is not directly responsible for state Medicaid enrollment and payment systems, agency officials said they are concerned that some state systems may fail. To help prevent this, the agency has begun to work with states on their Y2K problems.

HCFA's progress on the Y2K front is tempered by one unfortunate reality: some of the systems HCFA is expending so much energy and resources to modify to achieve Y2K compliance are obsolete and will need to be replaced soon after the year 2000. Y2K presented an immediate problem with an inflexible end point, which has forced HCFA to shelve its efforts to consolidate its Medicare claims processing systems and modernize other systems. After the termination of the Medicare Transaction System, HCFA decided to consolidate the number of systems that pay claims to reduce systems maintenance costs and streamline efforts to implement required systems changes. But systems consolidation could not go forward while HCFA and its contractors were renovating and testing their systems for Y2K readiness. As a result, it is spending millions to renovate certain systems for Y2K readiness that it plans to stop using soon after 2000.

HCFA Has Made Some Progress but Is Still Struggling With HIPAA and BBA Implementation

HCFA has completed many major tasks this past year and has implemented significant portions of HIPAA and the BBA, but progress remains slow. For example, HCFA has taken steps to allocate HIPAA funding and to implement authorities to combat waste and abuse in the Medicare program. HIPAA provided additional funds for HCFA's Medicare claims processing contractors to use to detect fraudulent and abusive billing practices. The claims administration contractors use these funds to hire and retain staff knowledgeable in conducting provider audits, claims reviews, and payment data analyses, among other activities. HCFA promptly issued the contractors' fiscal year 1999 budget allocations, unlike the situation in fiscal year 1998, when HCFA did not provide this funding to the contractors until a third of the year had passed.

[2] This problem stems from the use in many computer systems of a two-digit dating system for indicating the year. With this abbreviated format, the year 2000 is indistinguishable from 1900.

[3] *Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy* (GAO/AIMD–98–284, Sept. 28, 1998).

As part of HIPAA, the Congress also gave HCFA the authority to contract with specialists to perform payment safeguard activities. HCFA is now reviewing the submissions it received in response to its September 1998 solicitation for bids to become a program safeguard contractor. Such a contract could be awarded by May 1999, but the scope will be limited and will not provide many of the benefits initially envisioned from using a specialty contractor.

As part of its work on BBA-mandated Medicare+Choice,[4] HCFA issued interim final regulations for health maintenance organizations and other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations) to participate and took several steps toward implementing the new National Medicare Education Program last year. The regulations, published in June 1998, represented a massive undertaking accomplished within a very short time period. In rushing to reach the deadline, however, some of the provisions were developed without full consideration of their impact on managed care organizations. For example, the regulations required that managed care plans assess the health status of all new Medicare members within 90 days of enrollment, but this requirement would include existing plan members for whom the plan may already have comprehensive information. Similarly, the regulations require each managed care organization's chief executive officer to certify that the encounter data provided to HCFA are 100-percent accurate. To managed care plans, such a standard seems unreasonable because these data are generated from many sources not directly under their control, including contracting physicians, hospitals, and other providers. In addition, managed care plans are concerned that other requirements cannot realistically be accomplished in the required time frames, may be duplicative of existing accreditation and reporting requirements, and could create disincentives to work on more difficult quality improvement projects. HCFA has agreed to reconsider a number of items and is planning to change the standard for data accuracy so that plans' chief executive officers will certify to the best of their knowledge that the data provided to HCFA are accurate.

For the new National Medicare Education Program, HCFA established an eight-point plan for educating beneficiaries about their new managed care options; implemented an Internet site for providing comparative managed care plan information; and has begun phasing in its toll-free call center and its mail-out of a revised Medicare handbook to beneficiaries in five states, which foreshadowed the nationwide mail campaign planned for this fall. The effort to produce Medicare handbooks was more complicated than the agency originally expected. Of the 15 comparative handbooks mailed to beneficiaries in different geographic areas, 12 were inaccurate because HCFA published them before managed care plans finalized their Medicare participation decisions. The Congress' efforts to encourage the growth of Medicare managed care could be thwarted if plans refuse to participate and if beneficiaries are confused, instead of enlightened, about their many health care choices.

HCFA officials acknowledge they were slow to realize that the complexity and magnitude of the Y2K problem would stall implementation of key BBA requirements. The BBA mandated the design and implementation of new payment methods called prospective payment systems (PPS), which pay providers—regardless of their costs—fixed, predetermined amounts that vary according to patient need. To meet BBA targets, HCFA has to design and implement four PPS systems:

- a skilled nursing facility (SNF) PPS by July 1, 1998;
- a home health agency PPS by October 1, 1999, which was delayed by later legislation until October 1, 2000;
- a hospital outpatient PPS by calendar year 1999; and
- an inpatient rehabilitation PPS by fiscal year 2001.

The SNF PPS was implemented on July 1, 1998. However, to prevent additional complications during system renovation and testing for Y2K, the agency has missed deadlines to make systems changes needed for beginning the hospital outpatient and home health agency prospective payment systems. These delays could affect both budgetary savings and Medicare beneficiaries themselves. The Congressional Budget Office had estimated that new payment methods for home health and outpatient services would save Medicare about $23 billion between fiscal years 1998 and 2002. In addition, the hospital outpatient PPS would have reduced the amounts elderly patients pay for such services. HHS estimated that between January 1999

[4] Medicare+Choice widens beneficiary and health plan participation in Medicare managed care by (1) guaranteeing plans a minimum payment level, intended to encourage plans to locate in areas they had previously not served; (2) expanding the types of plans eligible to contract with Medicare to include—in addition to health maintenance organizations—preferred provider organizations and provider-sponsored organizations; and (3) informing beneficiaries of the plan choices in their area through a national information campaign.

and April 2000, senior citizens will have to pay an extra $570 million in higher copayments over what they would have paid if the hospital outpatient PPS had been implemented on time. While many Medicare beneficiaries have some sort of third-party coverage for costs that Medicare does not cover—referred to as "Medigap" policies—they are likely to be indirectly affected because premiums for Medigap policies are increasing in line with rising Medicare costs.

Although HCFA officials were tracking both BBA and Y2K implementation, top agency officials did not inform the Congress until July 1998 that the agency would be delayed in instituting the new payment methods. HCFA officials attributed their late awareness of this problem to communications breakdowns at three levels. First, they believe operations and policy staff at headquarters responsible for designing the program changes were not consulting with each other and with others who were responsible for implementing them in the field. Second, they stated that top agency officials did not immediately find out what lower-level HCFA managers knew—how long it would take to implement complex BBA changes and how that could complicate Y2K testing of the systems. Finally, officials believe that there was inadequate consultation with Medicare contractors responsible for making the actual programming changes to their systems.

While some parts of the BBA implementation were put on hold, HCFA moved quickly to implement a new SNF PPS.[5] However, we believe that the SNF PPS has design flaws, and coupled with a lack of adequate planned oversight, this may diminish the anticipated reduction in Medicare costs that prospective payment was supposed to create. Savings depend on developing an appropriate daily payment (per diem) rate to reflect patients' needs. The new daily payment rate is based on the average daily cost of providing all Medicare-covered skilled nursing services, adjusted to take into account the patient's condition and expected care needs. We are concerned that the new SNF PPS' design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services, since the amounts paid still depend heavily on the number of therapy and other services patients receive. Furthermore, HCFA has not planned sufficient oversight to prevent fraud and abuse. For SNFs, a facility's own assessment of its patients will determine whether a patient is eligible for Medicare coverage and how much will be paid. When Texas implemented a similar payment method for Medicaid, its on-site reviewers found that nursing homes' assessments were often inflated. Despite Texas' experience, HCFA does not currently have plans to monitor facilities' assessments to ensure they are appropriate and accurate. Nor has it ensured that the Medicare contractors—who pay the facilities' claims—will have timely information on patients to determine whether the rate to be paid is appropriate.

The last major BBA implementation challenge we want to highlight is the Children's Health Insurance Program—the largest health care investment in children since Medicaid was created in 1965. Although states are given broad flexibility in tailoring programs to meet their own circumstances, HCFA is responsible for approving each state's plan, providing technical assistance to the states, and ensuring that programs meet statutory requirements designed to guarantee meaningful health coverage. HCFA has initiated (1) a comprehensive effort with the states, private companies, advocacy organizations, the Health Resources and Services Administration, and others to promote this initiative and (2) an outreach effort to find those children who are eligible for health insurance under the Children's Health Insurance Program or Medicaid but are not enrolled. Since passage of the act, HCFA has approved 46 state plans, after providing extensive guidance and interim instructions to states. We are currently studying HCFA's and the states' efforts to implement the Children's Health Insurance Program and will report on the results later this year.

HCFA's Handling of Ongoing Responsibilities for Financial Management and Routine Oversight Raises Serious Concerns

Over the last several years, HCFA has been lax in managing critical ongoing program responsibilities, such as financial management—particularly by Medicare claims administration contractors—and oversight of nursing home compliance. For example, our work on high-risk programs such as Medicare highlighted the need for major federal financial management reforms, which the Congress initially enacted

[5] The prior payment method reimbursed providers on the basis of their costs, with capital costs and ancillary services virtually unlimited. Because providing more services generally triggered higher payments, facilities had no incentive to provide only necessary services or to improve efficiency. Prospective payment is intended to slow spending growth by paying providers fixed, predetermined amounts that vary according to patient need, regardless of providers' actual costs.

in the 1990 Chief Financial Officers Act and later expanded in the 1994 Government Management Reform Act. Under this legislation, the 24 major departments and agencies such as HCFA must now produce annual financial statements subject to independent audit, beginning with those for fiscal year 1996.

Since 1996, in conjunction with its audit of HCFA's financial statements, the HHS Office of Inspector General (OIG) has estimated the error rate for improper payments made by Medicare claims administration contractors. For fiscal year 1998, the OIG estimated that about 7 percent of Medicare fee-for-service payments for claims—$12.6 billion—did not comply with Medicare laws and regulations. This represents an improvement over fiscal year 1997, when the OIG estimated that Medicare contractors made $20.3 billion in improper payments—about 11 percent of all claims. However, the difference from 1997 to 1998 was almost entirely attributable to better documentation provided to the auditors, rather than to a substantive reduction in improper payments in categories such as "lack of medical necessity," "incorrect coding," and "noncovered services."

HCFA has made progress in strengthening its financial oversight. Nevertheless, serious weaknesses remain for both Medicare and Medicaid. Many of the financial weaknesses in Medicare relate to its oversight of Medicare claims administration contractors, which process over $700 million in Medicare fee-for-service claims each working day. In its audit of HCFA's 1997 financial statements, HHS' OIG found material weaknesses in managerial control over contractor operations, and, as a result, HCFA may not be collecting millions of dollars in overpayments from providers. The fiscal year 1997 audit identified one contractor transitioning out of the program that reported transferring $266 million in accounts receivable to other contractors, but neither HCFA nor the auditors could determine whether these receivables had been transferred onto the new contractors' books. HCFA depends on contractors' financial reports to provide information for its financial statement because HCFA lacks an integrated accounting system that can capture financial information at the contractor level. Moreover, the OIG found indications that HCFA's central and regional office oversight of operational and financial management controls was inadequate to ensure that contractor-provided financial information was consistent and accurate.

Similarly, the OIG found that security for contractor and HCFA information systems was inadequate, imperiling the confidentiality of Medicare beneficiary personal and medical data. While HCFA had corrected some weaknesses found during the audit for fiscal year 1996, it was still possible for an unauthorized user to gain access to HCFA's database and modify sensitive beneficiary files. HCFA has recognized the need to protect the security of its information systems and, starting in 1997, began revising security policy and guidance, and implementing corrective action plans. Because of the need to focus on Y2K modifications, however, HCFA probably will not address many of these weaknesses in the near term.

Medicaid financial management also is in need of reform. The OIG's 1997 audit revealed that HCFA had limited information on the federal portion of Medicaid accounts receivable and payable. In fiscal year 1997, HCFA relied on survey information from the states to estimate the amounts to record in the financial statements, and because the survey data were so limited, the OIG could not verify their accuracy. In addition, the audit noted that HCFA regional offices were not providing sufficient oversight of states' Medicaid claims processing and reporting, including states' efforts to deter fraud and abuse and collect overpayments.

HCFA's oversight of the quality of care Medicare and Medicaid beneficiaries receive also needs improvement. HCFA is responsible for defining requirements for certain providers, such as nursing homes and home health agencies, to participate in the Medicare and Medicaid programs and certify that their enforcement is adequate to protect the health and safety of Medicare and Medicaid beneficiaries. HCFA contracts with state agencies to review nursing homes and home health agencies for their adherence to these federal requirements. Our work has shown that HCFA's policies and oversight have been insufficient to ensure quality of care for nursing home residents or home health patients, and serious problems have resulted. One in nine nursing homes in the country were cited in both of the last two inspections for harming residents or putting residents' health and safety in immediate jeopardy—but such homes often faced no federal sanctions. In response, HCFA began taking actions to improve state inspection practices, revise state oversight activities, and strengthen enforcement for nursing homes. HCFA has also added requirements that home health agencies demonstrate experience and expertise in home care by serving a minimum number of patients before initially certifying them as Medicare providers. However, these steps may not go far enough to protect vulnerable beneficiaries. We are now reviewing HCFA's oversight of state nursing home complaint investigations and inspections and will report to the Congress on these issues this year.

HCFA Has Made Changes to Enhance its Management Capacity, But Problems Persist

Because its mission has been rapidly growing and changing, HCFA officials have worked hard to strengthen the agency's management capabilities. Despite these efforts, problems remain that hamper effective agency operations. While HCFA has developed a new focus on planning, including publishing a strategic plan, it does not require units to develop detailed plans to carry out day-to-day operations. The agency has completed its reorganization, but the resulting structure has contributed to various communication and coordination problems. Last year, HCFA lacked sufficient trained staff with the skills to effectively implement its top priorities. It hired more staff with needed skills in 1998, but it has not completed a long-term strategic approach to meet its future human resource needs. HCFA staff and managers are also concerned that its performance and award systems are not well linked to accomplishing its mission and that many managers are overburdened and lack managerial skills. These types of problems are found in other agencies, but HCFA still must be diligent in addressing them. The President's budget for fiscal year 2000 proposes a reform initiative for HCFA that is designed to increase its flexibility in the human resources area and to increase the agency's accountability.

Tactical Planning Is Limited

In December 1998, HCFA published its strategic plan, which focused on the organization as a whole and communicated the agency's vision, mission, and broad approaches to realizing that vision. This plan was developed to help HHS respond to requirements in the Government Performance and Results Act of 1993. In its strategic plan, HCFA clearly states that serving beneficiaries is its primary mission and, in doing so, the agency must be a prudent purchaser of health care. In addition to its overarching strategic plan, HCFA has also produced draft strategic plans for such significant areas as information technology and program integrity.

Strategic plans are an important first step; to be useful, however, they must be implemented. Tactical plans, which identify specific, measurable, desired outcomes; time frames; and assignments of responsibilities for task completion, are critical. Last year, we reported that HCFA was not planning its activities on a tactical level. Although tactical planning has been used in some specific instances during the past year, such as to help track implementation of BBA requirements, HCFA has still not institutionalized this level of planning in its day-to-day operations.

In our interviews and focus groups, a pervasive theme was the need to work in a crisis mode, made worse by a lack of planning. For example, a staff member stated that she was being pulled from one "hot project" to another—which caused her to lose efficiency because she barely managed to master one subject before she was tasked with another. A manager told us that since the reorganization, little planning has taken place in his division, making even simple tasks harder. He said, as an example, that the divisions did not know how much travel money was available until the middle of the fiscal year and that routine trips had to be written up as emergencies to get approval. We heard similar concerns from managers and staff working on data systems and coverage policy.

Reorganization Has Created Coordination Problems

HCFA's July 1997 reorganization established a totally new structure designed to better focus the agency as a "beneficiary-centered purchaser" of health care. The reorganization created new centers that were intended to respond directly to HCFA's customers—the Center for Beneficiary Services, the Center for Health Plans and Providers, and the Center for Medicaid and State Operations—and to provide additional resources to Medicare's growing managed care program.

In our January 1998 testimony, we noted that the agency's staff had not yet moved to the actual location of their new organizational units, which tended to exacerbate problems with internal communication and coordination. Almost a year after the reorganization, between June and August 1998, HCFA completed the physical relocations, placing staff within their new organizational units. Relocation was a major undertaking because HCFA had made dramatic shifts of groups and people. An estimated 80 percent of HCFA central office staff, along with their computers, files, and shared office equipment, were relocated during the move. Managers told us that the physical move was implemented well, minimized work disruptions, and enhanced HCFA's operational efficiencies.

The 1997 reorganization set out to eliminate HCFA's "stovepipes" by placing policy and operations staff together in specific customer-focused centers to enable them to work more closely together. We found that HCFA is still in the process of learning how to make its new organization work. Several managers said that they believe the quality of decision-making will be enhanced because input from many individuals and groups is required. But other managers and staff reported substantial internal and external communication problems as a result of the reorganization. For example, they said that the organization's decision-making process has become slow and cumbersome because it is more difficult to identify the key decisionmakers and find meeting times that can fit their busy schedules. We also were told that even identifying appropriate points of contact is sometimes difficult because new organizational titles are confusing. Finally, some managers and staff were concerned that when accountability for issues was shared by more than one center or office, tasks could "fall through the cracks" unless responsibilities were more clearly defined. Agency officials recognize that coordination is a problem and that there is sometimes a lack of accountability for decision-making. In response, they indicated that they are establishing teams on priority projects where key participants are identified and accountability for project completion is placed on one person.

HCFA's reorganization and emerging role as a health care purchaser and beneficiary advocate have also led to changes in the way HCFA communicates with those outside the agency. Some changes, such as those brought on by the Medicare +Choice program and the availability of Medicare and Medicaid information on the Internet, have increased interaction with providers, provider groups, and beneficiaries, according to several HCFA employees. Some staff we spoke with expressed concern about this increased workload and their inability to readily refer people to appropriate HCFA entities because the new organizational lines of responsibility are still unclear. Also, we found that although the Internet means that HCFA is "open 24 hours a day" and can communicate differently through this new medium, neither senior staff nor agency plans have fully addressed the impact of the Internet on HCFA's workload and how managers might need to reallocate responsibilities.

Maintaining Experienced and Appropriate Staff Will Continue to Be a Long-Term Need

Last year, we reported that HCFA lacked sufficient staff with needed skills to effectively implement top-priority tasks. Today, managers are somewhat less concerned about staffing shortages because, during the year, HCFA hired more than 400 new employees—a net gain of more than 250 after accounting for attrition. Of the new staff, a little over one-half were hired as GS–7s through GS–12s and about one-third were health insurance specialists. Senior agency officials told us that the new staff, with skills in areas such as managed care, private insurance, and market research, should help HCFA meet its new and growing responsibilities.

We believe that HCFA's focus on attracting new employees needs to be long term and continuous because it will continue to lose staff whose expertise must be replaced or supplemented. Over the next 5 years, almost a quarter of HCFA's staff—who make up a large part of the agency's management and technical expertise—will be eligible to retire. In addition, managers say HCFA will need staff with "real world" expertise in private industry, including those who know how to purchase care competitively. While HCFA has not fully assessed its long-term human resource needs, senior officials told us that the agency is taking initial steps toward developing a long-term plan for investing in its human resources. HCFA currently has a draft human resources plan that covers the years 1999 through 2003.

Performance System, Awards Program, and Flexible Work Hours Affect Agency Productivity

HCFA managers and staff discussed a variety of factors that hamper agency operations and limit effective management. Although we believe that HCFA is not unique in experiencing these problems, mitigating them could improve agency performance. These include a pass/fail performance rating system where virtually all staff pass, an awards program that does not necessarily reward superior performance, and flexible work schedules and locations that limit staff availability. Participants in our focus groups believed that HCFA's performance appraisal system for nonexecutive staff does not allow managers to meaningfully assess and report on staff performance because virtually everyone receives a passing grade. Staff believed that the pass/fail system is demoralizing to hard workers because no adverse action is taken for unsatisfactory performance. Similarly, according to managers and staff, the performance appraisal system does not give staff a sense of satisfaction when they perform well because it fails to recognize outstanding efforts. Some cited the prior performance system as preferable because exceptional performers could benefit by receiving more rapid pay increases.

The Administrator found that the performance appraisal system for executives was also not useful in holding managers accountable and made changes this year to better differentiate senior managers' performance. The executive appraisal system has changed to a system with five levels of performance. Each executive manager has a performance agreement that is linked to performance goals for his or her set of responsibilities.

Many managers and staff members also told us that the current awards program is not working. Although the program is intended to motivate staff, the opinions we gathered suggest that it may have just the opposite effect. Each unit establishes its own panel that makes award decisions and controls award amounts. Panels consist of an equal number of union-appointed and management-appointed representatives. Each panel sets its own criteria for making awards and determining the portion of its awards budget to give to managers for "on-the-spot" awards, which are awarded directly to staff for performance on specific projects throughout the year. Managers told us that they would like to be able to distinguish among the accomplishments of staff members and reward them accordingly, but both managers and staff perceive the awards process as lacking equity and integrity. Any staff member can nominate another for an award, and we were told that staff members sometimes nominate themselves and friends nominate each other. Managers also told us that sometimes almost all nominees in a unit receive awards because panels find it difficult to distinguish among nominees' performance. One manager who served as a panel member said that during the last fiscal year, about 250 employees were nominated for an award in his center—about two-thirds of all that center's employees. He said that only five of the nominees did not get an award. Last fiscal year, panels awarded about $678,000 to about 2,200 employees in grades 1 through 15—an average of about $300 per awardee. Managers also directly awarded about $213,000 through on-the-spot awards that can range from $50 to $250.

While staff were highly critical of the performance appraisal and awards processes, they approved of the flexibility to set their own work hours and work locations. HCFA's personnel rules provide for flextime—in which employees may arrive at work at different times each day within core periods or work longer hours in a day and earn time off—and flexiplace—which allows employees to work at alternative locations. Under these rules, however, staff who work in the office only 4 days a week may be off when their managers need them to be in the office. Managers also told us that more time can be taken up with administrative matters as a result of more flexible work arrangements. They said that managing staff is more complicated, noting that planning the work, managing resources, and scheduling meetings is difficult, for instance, when all of the staff are only required to be in the office during a core period from Tuesday through Thursday—3 days a week. Employees need special approval to begin flexiplace, and a senior manager told us that they are now only approving about half of such applications.

Managers and Staff Express Concerns About Management Capacity and Training

Some managers and staff discussed their concerns about supervisors' span of control and the lack of adequate training. They said that they believe some managers are responsible for supervising too many employees and do not have enough time to work with people who could benefit from on-the-job training. They also stated that some managers are not skilled at managing people, which they attribute largely to HCFA's tradition of promoting staff with excellent technical skills to the managerial level, and not rewarding them for developing their staff. Some also cited the lack of training provided to managers to improve their supervisory skills.

Many managers and staff agreed that HCFA does not provide enough training opportunities to help them do their work. We were told that new staff get little orientation to the agency's organization, programs, goals, and mission. Focus group participants added that limited training and travel funds prevented them from attending seminars and receiving training. Each HCFA staff member received an average of 8 hours of training last year. New staff, who generally were hired within the last year, averaged even fewer hours.

HCFA's senior management has identified management and other training as an area where HCFA must improve. The agency is developing a "model management initiative," which focuses on matching a manager's competencies with the specific skills that a manager needs for a given position. If approved by the Administrator, this model will be tested in the Office of the Chief of Operations. Then, if the initiative proves effective, it will be implemented in other parts of HCFA. HCFA is identifying better approaches to providing technical training and has doubled its training budget for next year—from about $800,000 in fiscal year 1998 to about $1.6 million in 1999.

HCFA Has New Proposals to Strengthen Management

To strengthen HCFA's ability to meet growing responsibilities, the President's fiscal year 2000 budget proposes several reform initiatives. The budget seeks more personnel and pay flexibility to allow HCFA to recruit high-level staff with specific, needed skills, such as physicians and executives with managed care plan operational experience. Coupled with such flexibility, HCFA is seeking authority to selectively offer buy-outs to some staff members. In addition, HCFA is seeking new authority that would allow it to contract competitively for its Medicare claims administration contractors. To improve agency performance, HCFA is proposing to add an advisory board of corporate executives and management experts for advice on improving its business practices. Finally, HCFA wants to increase its accountability to the Congress by providing biannual reports on its progress.

CONCLUSIONS

As HCFA moves into the 21st century, its challenges will continue to become more numerous and complex. Once it has finished preparing for Y2K, HCFA must face tasks it has had to put aside or has not fully addressed. Several immediate challenges lie ahead. HCFA must finish and then refine program changes to fully realize the benefits expected from the BBA. It also needs to renovate antiquated, and streamline redundant, computer systems. Furthermore, it needs to strengthen its financial management and efforts to preserve program integrity.

Added to these responsibilities will be potential additional challenges associated with any restructuring of Medicare that follows the deliberations of the Bipartisan Commission on the Future of Medicare. Even if no major changes are introduced, HCFA's continuing challenges are taxing—strong leadership and management will be required to meet them. More effective planning, new staff with needed skills, and better accountability could help HCFA address these challenges and better ensure quality health care for the elderly, poor, and disabled. A true measure of HCFA's success will be its ability to maintain current momentum as it enters the 21st century.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

Related GAO Products

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO/OCG–99–7, Jan. 1999).

High-Risk Series: An Update (GAO/HR–99–1, Jan. 1999).

Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy (GAO/AIMD–98–284, Sept. 28, 1998).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS–98–202, July 27, 1998).

Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives (GAO/T–HEHS–98–214, July 16, 1998).

Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS–98–160, June 1, 1998).

Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices (GAO/T–HEHS–98–162, May 6, 1998).

Financial Audit: 1997 Consolidated Financial Statements of the United States Government (GAO/AIMD–98–127, Mar. 31, 1998).

Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies (GAO/HEHS–98–93, Mar. 20, 1998).

Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T–HEHS–98–85, Jan. 29, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS–98–29, Dec. 16, 1997).

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse (GAO/HEHS–98–59R, Dec. 3, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation (GAO/T–HEHS–98–41, Oct. 29, 1997).

Chairman THOMAS. Thank you, Bill.

One of the things that I think is becoming useful is that this isn't a one-shot process. Our assumption is on your second-time around, there was a little more interaction and they were a little more comfortable and, perhaps, a little more insightful and willing to talk about certain situations.

You will be followed by a panel of contractors, and my concern is that some of the testimony from the contractors concerns me. The idea and the discussion between the Ranking Member and Ms. DeParle can be a launching point. It is always argued that HCFA has extremely low management percentages—2 percent, 3 percent. Testimony from Mr. Boston indicates that he believes that to a certain extent contractors subsidize HCFA in terms of those kinds of costs.

In addition to that, they are concerned about changes that are occurring in the way in which in attempting to follow the law they have the money for termination, either for profit or termination. But if you deny both, you simply can't function, and there seems to be from the panel that is coming—and that is why it is always difficult when you have this sequentially—an attitude that, perhaps, there is some malaise or discontent among the contractors.

In talking to HCFA, did you get some feeling—what does it seem to be in terms of the HCFA contractor relationship put in the context of last year, this year, tomorrow?

Mr. SCANLON. I believe that we did encounter tension between HCFA and the contractors, but not just over the last year. This is something I think that has been——

Chairman THOMAS. Building——

Mr. SCANLON [continuing]. Building over time. It partly reflects the fact that the administrative budget of HCFA has diminished relative to the workload that is being dealt with by the contractors and HCFA. HCFA's increased workload, in part, is compensated for by the automation that has occurred over the last decade. We have expressed concerns many times that so little program integrity activity today is being conducted relative to what was being conducted a decade ago. This limited activity is tied to the loss of program dollars to fraud and abuse.

We are also concerned that HCFA needs to be able to hold contractors accountable for being as efficient as possible with existing dollars, and we have been critical of HCFA for not being able to accomplish this. For example, HCFA has not been able to take best practices from some contractors and have these practices become the norm for all contractors. As you heard from Ms. DeParle, negotiating with contractors on the Y2K problem turned out to be a difficult chore. So, there definitely is a tension between HCFA and its contractors. It is partly an issue of a change that has occurred as the workload has increased. It is also, potentially, an issue of the structure of the relationship between HCFA and its contractors and the leverage that is on both sides.

Chairman THOMAS. We also hear a lot about how many new burdens or work requirements were placed on HCFA by BBA. I think the record needs to show also that we did provide additional moneys for BBA especially in the fraud and abuse area, and, as I recall, we were the ones who kicked off the user fee structure, because we provided some user fees in BBA. My guess is the Administration says, "Gee, let us go ahead and ask for them." It has not been successful in the areas they wanted to ask for them, because I think it made sense in the area of Medicare Plus Choice to help in the recruitment of patients of which the contractors would benefit. But there were additional resources.

Just a word or two on your reaction as to whether or not HCFA is getting its money's worth in terms of the way it has employed the new resources that were provided in the Balanced Budget Act of 1997.

Mr. SCANLON. We have not looked at this issue in enough detail to answer globally. We have looked at many specific areas, and we have noted the considerable progress HCFA has made in implementing both BBA procedures as well as moving forward on some program operation activities. We have also identified some of the areas where we think HCFA could have done a better job. However, I don't have, at this point, the ability to give you a score on how I would evaluate HCFA's net use of funds.

The BBA's requirements defined a new vision for the Medicare Program. It is a challenging task to change the program to conform to that vision. Although HCFA has made some progress, our concern is that progress needs to continue to be made for that vision to be accomplished, and there can be absolutely no let-up if that is going to happen.

Chairman THOMAS. Notwithstanding the fact that they are trying to ride bareback the Y2K bug at the same time, and we understand and appreciate that, but had they not gone off on the other tracking program; had they not had a one-shot silver bullet solution; had they not been as naive as they have been, perhaps the Y2K problem would have been addressed earlier. Is that a fair statement?

Mr. SCANLON. I think that is very fair. We were very hopeful that something like the Medicare Transaction System would be available, because, frankly, HCFA's computer systems need upgrading. HCFA needs better management information to operate this program. To be able to also solve Y2K would have been icing on the cake, so to speak. But we were also concerned that the Medicare Transaction System was not well planned, and, therefore, its demise was not unexpected.

Chairman THOMAS. And what bothers me is that we are spending an awful lot of money to get by the year 2000 on some wheezy stuff that is going to have to be replaced immediately after that, and it is probably not the highest and best use of limited resources, but necessary, nevertheless.

Mr. SCANLON. Right.

Chairman THOMAS. Thank the gentleman.

Mr. SCANLON. Thank you.

Chairman THOMAS. Gentleman from California—Louisiana—tried to recruit you.

Mr. MCCRERY. Yes, thanks. Just one question: Are you as comfortable as Ms. DeParle says she is with the Agency's—with HCFA's readiness for the Y2K eventuality?

Mr. SCANLON. In general, we have been pleased with the progress that HCFA has reported. We have been looking at its efforts to make a critical, external assessment of its progress. Mr. Willemssen will be testifying on this issue before the Full Committee later this month.

There are three areas we are looking at closely and which you will be hearing about then. First, we are looking at testing to ensure that systems can perform under varying circumstances.

The second issue is when these systems are put together and operate simultaneously, do they work effectively?

And third is an area that Ms. DeParle mentioned, which is the contingency planning. What happens when one component or another is not working—whether it is a regional, a provider, or an intermediary component—what do you do then? And how do you make sure that the system functions well in terms of continuing the payment-for-services?

Mr. MCCRERY. I guess I will just wait till later this month to——

Mr. SCANLON. Right. They didn't fill us in either.

Mr. MCCRERY. OK, thanks.

Chairman THOMAS. Does the gentlewoman from Florida wish to inquire?

Ms. THURMAN. It is amazing how quickly you become Ranking Member in these Committees. [Laughter.]

Chairman THOMAS. As long as it stops there, I am comfortable. [Laughter.]

Ms. THURMAN. I kind of like that, Mr. Chairman.

Actually, I just want to ask a couple of questions, because in some of your remarks or in our booklet here, you talked about some of the issues that the President has put in his budget that you think might strengthen. Have you looked at those, and can you comment on any of those issues?

Mr. SCANLON. We have looked at what I would call the outlines of these proposals, because the details are not there. In many ways, the proposals address some of the issues that we have encountered in our interviews at HCFA and also in our work on other portions of HCFA's activities over the year.

Getting this agency to be more flexible, to be more accountable, to focus on productivity, are things that are very important. We think that the proposals relative to personnel and to bringing in outside management experts to provide them with advice are aimed in that direction.

HCFA's relationship with its contractors has been problematic, and there is the potential that, with the right set of reforms, this relationship could improve. Therefore, the idea of contractor reform is something generically we may support; the devil would be in the details.

The idea of HCFA focusing on the management of the program may relate to its relationship to the Department. HCFA has often engaged a major portion of its time on policy initiatives versus program management. It really needs a focus on program management for the program to work effectively, and we are hoping that this foucs is something else that emerges from these reform proposals.

Ms. THURMAN. You mentioned that they needed maybe to bring in some outside management. Is that where this issue of potential higher salaries is coming from? I am not——

Mr. SCANLON. Well, it is, I think, in two ways: one is the issue of potential higher salaries, because, frankly, HCFA would like to attract individuals with operations expertise, particularly from the managed care area, who could assist them in doing things like designing the Medicare Plus Choice requirements and being able to take into account truly what it is like to operate a managed care organization. Frankly, those individuals are valuable in the private sector, so to woo them away for government may take additional dollars.

The second activity is bringing in an advisory panel made up, perhaps, of CEOs of private companies—insurance companies as well as, perhaps, some other kinds of service companies—that could talk about the way they structured their successful organizations and what lessons might be applicable to government. That activity, if it is going to be useful, will have to take into account the unique aspects of a governmental agency as opposed to a private sector company.

Ms. THURMAN. OK, thank you.

Mr. SCANLON. Thank you.

Chairman THOMAS. Any additional questions? Thank you very much.

Mr. SCANLON. Thank you.

Chairman THOMAS. Same time next year. [Laughter.]

Could we now ask for the third panel consisting of Barbara Gagel, chairman of the Anthem Alliance in Indianapolis, Indiana on behalf of the Blues; Ned Boston, from the Wisconsin Physicians Service Insurance Corp., and David Bryan, vice president of EDS Health Care Senior Markets in Plano, TX.

Thank you very much. The written testimony that you have provided us with will be made a part of the record, without objection. Ms. Gagel, we will just start with you; we will move across the panel, and thank you very much for coming, and we look forward to your testimony.

STATEMENT OF BARBARA GAGEL, CHAIRMAN, ANTHEM ALLIANCE HEALTH INSURANCE COMPANY, ANTHEM BLUE CROSS AND BLUE SHIELD, INDIANAPOLIS, INDIANA, AND BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. GAGEL. Thank you very much for inviting us. I am pleased to be here today. For more than 30 years, Blue Cross Blue Shield plans have partnered with the Government to handle the day-to-day work of paying Medicare claims accurately and timely. We are extremely proud of our role as Medicare contractors.

Contractors have several traits: one is that they are cost-effective, operating on administrative budgets that today represent only approximately 1 percent of Medicare benefit payments; contractors are efficient, having a track record of quickly and accurately implementing major programmatic changes under extremely tight timeframes, and, importantly, Medicare contractors very aggressively pursue Medicare fraud and abuse. As you have heard this afternoon, the extra funds provided by this Committee for the Medicare Integrity Program are having excellent results. Yesterday, the HHS Inspector General did report a 45-percent reduction in overpayments since 1996.

Mr. Chairman, I would like to especially thank you for allowing us the resources so that we can improve our performance in this area.

My testimony today will focus on three areas: first, is our progress in assuring that the year 2000 computer adjustments are made correctly and timely; second, why new Medicare contracting legislation is unwise and could jeopardize our efforts to fight fraud and abuse, and, third, the critical need for stable and adequate funding for Medicare contractor operations.

Let me speak first to Y2K readiness. It is a top priority of Medicare contractors. We are making, as Mr. DeParle indicated, excellent progress to ensure that Medicare payments are renovated and tested for millennium compliance. We are working closely with HCFA in this regard and have for at least the last 12 months now. In my written testimony, I talk to you about the activities that are under way at Anthem to assure that this will happen in our four States. There is an immense amount of work that remains to be done with regard to Y2K, although Medicare contractors, the majority of them, did certify to the adequacy of their systems at the end of December of this year. It is very important to understand that tremendous testing will continue to need to be done, as Mr. Scanlon indicated, throughout 1999 to assure that claims will be paid correctly in the year 2000.

Contractor reform we think is unnecessary and unwise at this point in time. HCFA is again proposing legislation that would dramatically restructure the Medicare contracting process. This legislation would permit HCFA to fragment the functions of current contractors. We do not think we should be doing this at this point in time. All Medicare contractor functions—and the primary functions are claims processing, customer service, and fraud and abuse activities—are linked and need to be integrated to be successful. Separating the functions as HCFA intends to do, represents trouble for Medicare contractor operations and particularly for the fraud and abuse activities. Contractor functions are not autonomous, and moving forward with contractor reform and the split-off of these functions needs to be done very, very, very carefully to protect services for Medicare beneficiaries going forward in the future.

Finally, let me point to the need for stable and adequate funding. It is absolutely critical to the performance of Medicare contractors. While the additional Medicare Integrity Program funding is helping us to strengthen our efforts to fight fraud and abuse, the large majority of contractor operations remains subject to the annual appropriation process and the tight budget limits that apply to those funds.

So, we have a very, very, very short time line always that we are dealing with. We don't have the opportunity as Medicare contractors—and HCFA, of course, doesn't have the opportunity—to really think and plan long range and make the kinds of investments in the program that are necessary for it to be a top notch program. So, we do need stable funding, and we look forward to working with this Committee in ways to assure that there is stable funding in the future. Thank you.

[The prepared statement follows:]

Statement of Barbara Gagel, Chairman, Anthem Alliance Health Insurance Company, Anthem Blue Cross and Blue Shield, Indianapolis, Indiana, and Blue Cross and Blue Shield Association

Mr. Chairman and members of the committee, I am Barbara Gagel, Chairman of Anthem Alliance Health Insurance Company, a subsidiary of Anthem Blue Cross and Blue Shield. I am testifying on behalf of the Blue Cross and Blue Shield Association, the organization representing 52 independent Blue Cross and Blue Shield Plans throughout the nation.

As a former contract officer at the Health Care Financing Administration (HCFA), I am pleased to see that the agency has made improvements in managing the Medicare program. I appreciate the opportunity to testify before you today on this important issue.

The Medicare program is administered through a successful partnership between the private industry and HCFA. Since 1965, Blue Cross and Blue Shield Plans have played a leading role in administering the program. They have contracted with the federal government to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner.

Nationally, Blue Cross and Blue Shield Plans process over 90 percent of Medicare Part A claims and about 67 percent of all Part B claims. At Anthem, we process about 18 million Part A claims and 37 million Part B claims each year.

Responsibilities of Medicare Contractors

Medicare Contractors have four major areas of responsibility:

1. *Paying claims.* Medicare contractors process all the bills for the traditional Medicare fee-for-service program. In FY 2000, it is estimated that contractors will process over 900 million claims, more than 3.5 million every working day.

2. *Providing Beneficiary and Provider Customer Services.* Contractors are the main point of routine contact with the Medicare program for both beneficiaries and providers. Contractors educate beneficiaries and providers about Medicare and respond to about 40 million inquiries annually.

3. *Handling Appeals for Payment.* Contractors handled more than 7 million hearings and appeals for reconsideration of initial determinations last year. In FY 2000, HCFA expects the cost to process appeals and hearings to rise by ten percent.

4. *Fighting Medicare fraud, waste and abuse.* Contractors saved $8 billion in 1997, yielding $17 in Medicare savings for every $1 invested from activities to review claims, to assure services are medically necessary, and to detect possible fraud and abuse.

Medicare contractors successfully have met many significant challenges during this thirty-four year partnership. These include:

- Handling a dramatic increase in workload that has grown from 61 million claims in 1970 to an estimated 935 million in 1999.
- Quickly implementing major programmatic changes under extremely tight timeframes, such as the institution and refinement of the Medicare prospective payment system for hospitals, the physician resource-based relative value payment system, and several payment system changes required by the Balanced Budget Act of 1997.

We are very proud of our role as Medicare administrators and our record of efficiency and cost effectiveness for the federal government. In 1998, contractors' administrative costs represented less than 1 percent of total Medicare benefits. While workloads have increased dramatically, operating costs—on a unit cost basis—have declined about two-thirds from 1975 to 1998.

My testimony today focuses on three areas:

I. Progress on our current major challenge: assuring that Year 2000 computer adjustments are timely and accurate;

II. Why new contracting legislation is unnecessary; and

III. The critical need for stable and adequate funding to assure the efficient administration of Medicare.

I. Progress on Efforts to Assure Year 2000 Readiness

Year 2000 readiness is a top priority for Medicare contractors. Medicare contractors are making excellent progress to ensure Medicare payment systems are renovated and tested for millenium compliance. HCFA has reported that as of December 31, 1998, 57 of the 78 contractors and shared systems self-certified without significant qualifications. Most of the remaining contractors are on target to self-certify by March 31, 1999, without significant qualifications.

Contractors are now working to complete their testing and to finalize contingency plans. In addition, contractors are focusing on readiness preparation of the provider communities.

Although there is still much to be done, significant and steady progress has been made. We are confident that contractors will be ready and that claims will be paid properly on January 1, 2000.

Let me describe for you the efforts my company has made to become ready: We began planning for Y2K renovation in 1996 with the goal of paying or denying Medicare claims correctly on and after January 1, 2000. By December 31, 1998, we had inventoried software and hardware, reviewed the LAN and WAN environments, assessed millions of lines of code, renovated code, retired modules, upgraded hardware to make it Y2K compliant, tested each module, and established a simulated production environment.

We then ran test cases—test claims—through the entire claims processing system to ensure that the system processes the claims, with the same result, both before and after the Y2K renovation. This is a full simulation of production. We want to be sure that all steps in the process are capable of supporting business after 2000. We tested 11,403 claims using eight different dates that spanned late December 1999 to early January 2000, and February 28 through March 1, 2000. Based on the results of these tests, we were able to certify Y2K compliance to HCFA as of December 31, 1998.

Even with this certification, much remains to be done in 1999. We will continue our integration testing, and plan to test 50,000 claims and recertify compliance to HCFA by November 1, 1999. It is critically important that all changes from HCFA be completely tested. We will engage providers who submit bills electronically in "end to end testing," to assure that providers can submit claims to us, and that we can receive them and provide a remittance advice. And, importantly, although we don't expect failure, we are developing and testing contingency plans for all mission critical applications and business partners.

We have 25 people devoted full-time to the Y2K project. An additional 50 people supported Y2K testing in 1998 on a part-time basis. These numbers will increase to 145 people as recertification testing and contingency planning testing and rehearsals reach intense levels in mid–1999.

BCBSA Efforts with HCFA to Ensure Compliance

BCBSA and Medicare contractors have been working closely with HCFA on compliance issues. Last year, BCBSA worked with HCFA to find an agreeable contract amendment related to Year 2000 compliance. In addition, we worked with HCFA to develop a formal process to assure regular communication on Y2K issues. In response to a BCBSA recommendation, HCFA established a steering committee chaired by HCFA's chief information officer and vice-chaired by BCBSA.

I serve on this steering committee. Let me briefly describe the significant areas that are being addressed by the committee:

1. Progress Measurement—Monitors the progress of individual contractors and contractors as a whole.
2. Critical Path—Identifies necessary activities, risk points, and key assumptions for Year 2000 compliance.
3. Provider Relations—Informs providers about Year 2000 issues and provides training.
4. Common Testing Protocols—Develops testing procedures.
5. Contingency Planning—Determines processes and time frames for paying providers if mission critical systems are not Year 2000 compliant.
6. Resource Allocation—Defines standard definitions for Year 2000 activities and estimates costs.

Very good progress is being made. As an example, the Contingency Planning group has developed a protocol that is supported by a comprehensive planning template applicable to any mission critical risk a Medicare contractor might identify in its operations. While contractors are already developing contingency plans, the work group's combined input into development of this protocol has produced a tool that can add significant value to this process and produce uniform planning documentation.

Beyond the specific products, operation of the steering committee has facilitated very constructive and useful dialogue between contractors and HCFA about Year 2000 compliance. The committee has met with the HCFA administrator and meets monthly with many of the agency's key directors and other top management staff. We look forward to continuing these cooperative efforts with HCFA.

In reviewing the issues related to Year 2000 compliance, the committee should be aware of three additional issues that have made Year 2000 readiness activities even more challenging:

- *Significant Change in Direction.* Originally, many of the system changes that were necessary for readiness would have been accomplished by the conversion of all Medicare contractors to the Medicare Transaction System (MTS). As you know, the MTS initiative was dropped in 1997. As a result, contractors have been required to make significant changes that, in the absence of the MTS initiative, they would have been working on for a long time.
- *Transition to New Standard Systems.* Instead of converting to the MTS system, HCFA had directed contractors to transition to a single Part A and a single Part B system. In some cases, this conversion to different systems would have diluted experienced contract and HCFA staff from focusing on critical millenium readiness activities. As a result, HCFA approved a request by several contractors to delay transition requirements so they could focus on Year 2000 issues.
- *Numerous and Broad Programmatic Demands.* HCFA already has said that it will not be able to implement all of the BBA requirements because of the need to concentrate on Year 2000 efforts. We continue to recommend to HCFA that as many non-Year 2000 system changes as possible should be removed from contractor workloads so that experienced technical resources can be devoted to assuring Year 2000 readiness.

II. CONTRACTOR REFORM IS NOT NECESSARY

HCFA's FY 2000 budget once again includes a legislative proposal to dramatically restructure the Medicare contracting process. This effort to make broad changes in contract authority is not a new initiative. For several years, HCFA has been seeking contractor reform legislation that would give HCFA broad authority to fragment the functions of current contractors. While we have not yet seen the details of this current proposal, our understanding is that it is similar to previous legislation.

We believe that contractor reform provisions are unwise and unnecessary for the following reasons:

1. *It could jeopardize services to beneficiaries and providers.* HCFA's proposal would eliminate the requirement that Medicare contractors have experience working with the Medicare program and would not even require that entities be familiar with health claims processing. Allowing HCFA to contract with organizations unfamiliar with Medicare's intricate payment methodologies could reduce payment accuracy, delay payments to providers, and reduce the quality of service providers and beneficiaries expect.
2. *It could undermine HCFA's efforts to administer its other initiatives effectively.* Potentially, HCFA would have to manage many new contracts for claims processing services with entities unfamiliar with Medicare. These new contracts would require strict management by HCFA at a time when HCFA has many other new responsibilities, including BBA and HIPAA. With these other large workloads, we believe the agency does not have the resources, staff, or expertise to implement this type of new procurement activity.
3. *It is based on the flawed Medicare Integrity Program.* HCFA has just begun to implement the new contracting provisions for the Medicare Integrity Program (MIP). As of yet, no contracts have been awarded. Further authority for HCFA to significantly revise contracting relationships is premature. Moreover, we believe that HCFA's strategy to split the MIP functions from the Program Management (PM) functions in Medicare is flawed. Due to the historical and functional integration of claims processing, customer service, and fraud and abuse activities, separating PM and MIP functions represents potential trouble for future fraud and abuse detection. PM and MIP are not autonomous services, and require constant coordination and communication in a rapidly changing Medicare program.
4. *It would place Medicare contractors under legislative constraints that exceed other government contractors.* The legislation eliminates the requirement that HCFA pay termination costs to contractors that leave the Medicare program. This provision would make Medicare contracts different than any other type of government contract, including defense contracts. The Federal Acquisition Regulations (FAR) require that the government pay contractors reasonable termination costs. There is no basis to treat Medicare contractors differently.
5. *HCFA's proposals could impede contractors' progress to become Y2K ready.* At this point, HCFA's proposal would not improve the Year 2000 problem, and, in fact, could make it much worse. Contractors unfamiliar with the Medicare program would have the added burden of having to learn its extremely complex rules and regulations while simultaneously working to achieve millenium readiness. Moreover,

the testing requirements for contractor certification are extremely complex given the number of links contractors have with external systems (e.g., HCFA, banks, providers, etc.). It is highly unlikely that HCFA would be able to identify a new contractor that could meet the certification requirements.

Finally, contractor reform is unnecessary to ensure the quality of Medicare contractors. HCFA currently has the authority to replace or terminate contractors for poor performance.

HCFA has marketed this proposal as increasing cost effectiveness of contractor operations. However, this legislation has no positive effect on the budget. It does not reduce expenditures for Medicare contractors. More importantly, inexperienced contractors could potentially harm the trust funds by increasing improper payments.

Success in Medicare claims administration requires that HCFA and the contractors work together toward their mutual goal of accurate and timely claims payment. This partnership should extend to planning the future of Medicare contract administration. We believe the most effective manner to proceed in strengthening Medicare administration is to raise performance standards, aggressively enforce them, and terminate the contracts of those not performing at the required level.

III. Stable and Adequate Funding is Critical

As Medicare's first line of defense against fraud and abuse, Medicare contractors require adequate funding in order to meet the demands of the program and to effectively combat fraud and abuse.

The President's FY 2000 budget proposes $1.27 billion for Medicare contractors, virtually the same funding level as 1999. Of this total level, $93 million is dependent on proposed new user fees from providers, which have previously been rejected by this Subcommittee.

In addition, the President's budget requests $150 million for HCFA millenium readiness. It is unclear, at this point, how much of these proposed funds would be made available for Medicare contractors' Y2K needs.

We strongly support HCFA's efforts to secure additional funding for Year 2000 activities. However, we are extremely concerned that HCFA's budget once again puts the effective administration of Medicare at risk by relying on proposed user fees to fund contractor activities.

Moreover, additional funds will be needed to cover a significantly greater workload next year, including:

- Implementing BBA provisions, including new prospective payment systems for inpatient rehabilitation facilities and outpatient hospital care.
- Implementing HIPAA administrative simplification provisions, including the national payer identifier initiative and the development of transaction and security standards for electronic processing of claims.

Adequate funding is critical to maintain anti-fraud efforts and to prevent further service reductions to beneficiaries and providers. An independent study commissioned by BCBSA last year indicates that contractor funding will be significantly strained by the increased anti-fraud and abuse detection efforts under the newly enacted MIP. The report shows that every 10 percent increase in MIP funding will result in a $13 million increase in contractor costs due to increased appeals, inquiries, and hearings.

Additionally, a letter published in a recent Health Affairs journal, signed by 14 health policy experts, stressed the need for more Medicare administrative funding. Specifically, the letter stated that "HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources."

We believe that finding a reliable and stable funding source for Medicare contractors is critical. In the President's budget, HCFA indicated a willingness to explore alternative funding options for Medicare administrative activities. We support HCFA's efforts and would like to work with HCFA and Congress to move toward a stable and reliable funding source.

Conclusion

Let me reiterate that Medicare contractors are working diligently to become millenium ready. This is a monumental task, and we will face a number of challenges along the way. Medicare contractors are committed to meeting these challenges just as they have done in the past.

Congress should reject HCFA's request to legislate far-reaching changes to the Medicare contractor program. Contractor reform raises fundamental issues and implications for the Medicare program. In fact, contractor reform would introduce change, confusion, and diversion of resources at a time when experience and focus is important. Alternatively, HCFA should tell contractors exactly what standards they want contractors to meet. Let contractors meet these standards; otherwise, HCFA can terminate our contracts.

Finally, given the importance of Medicare to its beneficiaries, providers, and the nations' economy, it is critical that the administrative resources necessary to manage the program effectively be provided.

Chairman THOMAS. Thank you very much. Mr. Boston, I thank you for what I consider to be unusually candid written testimony provided for this Subcommittee and look forward to your oral testimony.

STATEMENT OF NED BOSTON, VICE PRESIDENT FOR MEDICARE, WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION, AND MEDICARE ADMINISTRATION COMMITTEE

Mr. BOSTON. Thank you, Mr. Chairman. My name is Ned Boston. I am vice president for Medicare with Wisconsin Physicians Service Insurance Corp. in Madison, Wisconsin. WPS is the Medicare Part B carrier for the States of Wisconsin, Michigan, and Illinois.

At the moment, WPS is Medicare's largest carrier and will process approximately 70 million claims this year. To give you a prospective on that, WPS will process this each minute of each working day this year over 500 health care claims, and that ties to what Ms. Gagel was talking about a little bit ago about the intricate and interrelated nature of the kinds of systems that we administer.

I am appearing today on behalf of the nine commercial insurance companies that comprise the Medicare Administration Committee. Our members serve Medicare as carriers, intermediaries, and regional durable medical equipment carriers. In fiscal year 1998, our members processed 258 million Medicare claims. My testimony will focus on a few limited areas and amplify some things that were in my written testimony.

My first and foremost concern I want to express to the Subcommittee is in the area of year 2000 readiness. If we, as contractors, and HCFA fail to achieve Y2K readiness, the orderly processing of 900 million claims on behalf of Medicare beneficiaries could grind to a halt. Both the Agency and its contractors are and have been hard at work on the modifications and testing that will assure that we are ready for the millennium. The professional staff at our carriers and intermediaries have been devoting thousands of hours of overtime to getting the job done while pursuing all of their regular job functions processing Medicare claims.

HCFA has pushed its contractors very hard to modify and successfully test their systems. We are confident that if the current rate of progress continues, there will be few, if any, Y2K problems in the Medicare Program itself. We are, however, vitally concerned about the progress we see from those health care organizations who are billing the Medicare Program.

Contractors first brought Y2K concerns to HCFA's attention more than 4 years ago, but the problem had to compete with other priorities and, as you have heard earlier, with the thought that the Medicare Transaction System might solve all these issues. As continued analysis of the scope and implications of Y2K has heightened everyone's understanding and the immensity of the problem, HCFA has accorded it the highest priority in its management of its multiple responsibilities. From the perspective of carriers and intermediaries, the greatest problems have been finding and retaining expert staff to do the kind of work necessary to fix the systems. We are very pleased that in this effort there has been sufficient financial support from the Congress and from HCFA that have allowed us to do this.

Despite an occasional frustration we have experienced with HCFA over some of the details, we are going to be ready. However, just because we have certified that we are ready for Y2K as of this date, doesn't mean that we do not have a very busy year in front of us in 1999. We must spend this year completing our contingency planning for what happens if something is not available. What happens if the electrical power doesn't work? What happens if major health care delivery systems are not able to submit bills? There are many factors that could affect us.

My message to you would be that what we need in 1999 is a stable Medicare Program with very few changes that we need to implement so that we can concentrate on recertifying, retesting, and testing again to make sure that we are prepared for the millennium. If we try to implement a great rate of change in this calendar year, we could jeopardize our readiness.

Let me spend just a minute talking about the Medicare Integrity Program. Our Committee supports the cautious and incremental approach that HCFA is taking in its Medicare implementation program strategy. If carried forward, this program would involve transitioning huge workloads to new contractors. Although HCFA has some experience with these transitions, they have not always been successful. Some of the new contractors may not have had prior Medicare experience. We believe it is wise to start on a small scale and incorporate the experience gained in each successive expansion of the program. The incremental approach may be the largest lesson that we have learned from the Medicare transaction system; sometimes, the big bang theory simply doesn't work.

It is important to note that the contractors are continuing to perform fraud and abuse activities while this new program is getting ready, and despite the intended stable funding for these activities, some contractors, including WPS, received less this year for fraud and abuse activities than we received in the last fiscal year. We are trying to do everything we can within those funds to make sure that we complete our obligations to the program.

And, finally, addressing for a moment contractor reform—and the work reform is one that we find difficult. We believe what HCFA is seeking is simply a different way of contracting for the administration of the program. Reform to me indicates a need for a change; we believe HCFA wants a change. We believe HCFA has a great many powers that they have not necessarily used in the area of competitive procurements and on other than cost reimbursement basis. We would certainly be willing to work with HCFA on those things, but we caution, again, that a slow incremental approach be used. We are processing 900 million claims on behalf of almost 40 million beneficiaries. Any change to the system needs to be very, very carefully considered.

Mr. Chairman, that concludes my oral testimony, and I would be delighted to answer any questions the Committee may have.

[The prepared statement of Mr. Boston follows:]

Statement of Ned Boston, Vice President for Medicare, Wisconsin Physicians Service Insurance Corporation, and Medicare Administration Committee

Mr. Chairman, members of the Subcommittee, I am Ned Boston, Vice President for Medicare of Wisconsin Physicians Service Insurance Corporation. My company is the Medicare Part B carrier for the states of Wisconsin, Michigan and Illinois. At the moment WPS is Medicare's largest carrier. This Fiscal Year we expect to process approximately 70 million claims for the Program.

I am appearing today on behalf of the nine insurance companies that comprise the Medicare Administration Committee. Our members serve Medicare as carriers, and/or intermediaries. Two of our members are also regional durable medical equipment carriers (DMERCs). In Fiscal Year 1998, our members processed 258 million Medicare claims.

We appreciate your invitation to appear today to discuss the management of the Medicare Program.

My testimony will focus on five topics.

- Medicare Contractor readiness for the Year 2000;
- The Medicare Integrity Program;
- Proposals to restructure or "reform" the administration of Medicare;
- Funding of Medicare contractor operations; and
- Why some Medicare carriers and intermediaries are leaving the program.

The past decade has been a difficult one for the Health Care Financing Administration and for its Medicare contractors. While the agency has been formulating strategies for the future of Medicare, the fee for service claims workload has grown steadily. However, the funding, measured on a per claim basis, has declined. In addition, Congress has legislated numerous complex changes in both Part A and Part B that have required considerable additional effort beyond the ongoing energy and resources that go into processing over 3 million Medicare claims each working day. While the growth of the Medicare + Choice portion of Medicare may someday reduce the workloads of those of us involved in the fee-for-service segment of the program, we have yet to see that happen. Based upon the constantly increasing number of seniors and the limited number who have elected managed care, we believe that the traditional Medicare fee-for-service program will exist for many more years.

YEAR 2000 READINESS

The fact that most computer systems in place in both government and the private sector allow only two digits to be used to indicate a year means that computers are not able to distinguish between dates in the 20th and 21st century. This simple problem has amazingly complex and calamitous implications that, world-wide, are costing billions of dollars to avoid. Equipment must be modernized, millions of lines of computer programming must be thoroughly studied, the linkages with other program segments must be traced, and corrections designed and implemented in order to assure the smooth transition of business and government to the next century.

For HCFA, the number of contractors and the number of electronic data processing (EDP) systems affected by the Y2K problem constitute a major management challenge. If we and HCFA fail to achieve Y2K readiness, the orderly processing of 900 million claims by more than 65 contractors on behalf of Medicare could grind to a halt. Both the agency and its contractors are hard at work on the modifications and testing that will assure that Medicare is Y2K ready. While becoming Y2K ready is an expensive process, it should be noted that professional staff at carriers and intermediaries have been devoting thousands of hours of overtime to getting the job done, while also pursuing their ongoing Medicare duties.

HCFA pushed its contractors very hard to modify and successfully test their systems for Y2K by the end of 1998. The vast majority of contractors did meet the December 31, 1998, deadline with regard to their mission-critical information processing systems. The few that were not able to document their full compliance with HCFA's guidelines at the end of last year are expected to be fully ready by the end of March, which is the government-wide deadline for achieving that status. The cooperative effort between HCFA and its contractors has achieved an immense amount of progress over the past six months. We are confident that if the current rate of progress continues, there will be few if any Y2K problems in the Medicare program, itself. We are, however, vitally concerned about the progress we see from those health care organizations billing the Medicare program.

Looking back, it is fair to say that HCFA and its contractors got off to a slow start on Y2K. Contractors first brought their Y2K concerns to HCFA's attention more than four years ago, but the problem had to compete for priority with many other important projects for which HCFA is also responsible. As continued analysis of the scope and implications of Y2K has heightened everyone's understanding of the immensity of the problem, HCFA has accorded it the highest priority in the management of its multiple responsibilities.

The initial response from HCFA concerning Y2K was that virtually all Medicare EDP systems would be replaced by the Medicare Transaction System (MTS) which was then under development. The MTS would be Y2K compliant, and, since it would be in place before the end of the century, it would take care of the Y2K problems that concerned contractors.

In late 1996, HCFA came to the realization that it would not be possible to replace all existing systems in one massive transition to MTS. It abandoned the "big bang" approach and instead adopted an incremental strategy for modernizing Medicare's claims processing and data management functions. Later, when HCFA acknowledged that the MTS initiative had failed to progress as hoped and shut the project down, it decided to move all carriers and intermediaries to standard core EDP systems, one each for Part A, Part B and durable medical equipment, as a transitional step toward realizing some of the goals of MTS.

HCFA planned to move its carriers and intermediaries to the standard claims processing systems incrementally over a two year period. However, for nearly all contractors, the standard systems conversions required the efforts of the same expert personnel that were needed for Y2K. It took awhile for HCFA to accept that both jobs could not be accomplished simultaneously within the time frames they had set. Once they became convinced, they modified their standard systems conversion schedules to give precedence to Y2K. They also cut back on the issuance of routine system updates that tended to interfere with Y2K work, although those updates still have not been entirely eliminated.

Despite some initial uncertainty about financing, getting the money to pay for Y2K renovations and testing has not proven to be a big problem. From the perspective of carriers and intermediaries, the greatest problems have been finding and retaining scarce expert staff to do the work, and getting the necessary guidance and approval from HCFA that is required for work to proceed within an increasingly tight time frame. Despite the occasional frustrations we have experienced with HCFA over some details of the Y2K effort and over trying to conform with detailed agency guidelines that keep changing, we believe that the agency deserves a lot of credit for planning and defining the complex work to be done and for its coordination of the efforts of so many contractors. HCFA has achieved a great deal of progress in a short period of time.

We realize that, in giving singular priority to making Medicare Y2K ready, HCFA has postponed a number of other very important projects mandated by Congress. While we contractors do not wish to second guess the agency's judgments about which projects should proceed and which should be postponed, we do support the Administrator's decision to make Y2K readiness HCFA's singular top priority. The chaos produced by a collapse of Medicare's information, claims processing and payment systems surely would be far more damaging to the Medicare program's beneficiaries and partners than the delay that Y2K has caused in other HCFA projects from which the program will eventually benefit.

Medicare Integrity Program

Despite all of the attention being devoted to Y2K, HCFA is proceeding in a deliberate manner toward implementation of the Medicare Integrity Program (MIP) mandated by the Health Insurance Portability and Accountability Act (HIPAA). It has received and is now evaluating bids received from potential program safeguard contractors and has just issued an RFP for a coordination of benefits contractor. An RFP has not yet been issued for a statistical analysis contractor.

Under HCFA's strategy, the work performed by MIP contractors will be integrated with that performed by carriers and intermediaries employing the standard Part A, B and DME systems that I mentioned earlier. While HCFA intends to implement the MIP program incrementally, eventually it will greatly reduce the number of contractors performing audits, medical reviews, and fraud investigations.

Our committee supports the cautious, incremental approach that HCFA is taking in its MIP implementation strategy. The evolution of this program will involve the transitioning of huge workloads to new contractors. HCFA has gained considerable experience in contractor transitions, but they have not always gone smoothly. Since some of the new MIP program safeguard contractors HCFA selects may not have prior Medicare experience, we believe it is wise to start on a small scale and incorporate the experience gained in each successive expansion of the program. This may be one of the major lessons learned from the MTS initiative.

Many current carriers and intermediaries decided not to bid for the role of MIP program safeguard prime contractor—though some did and several others may serve as subcontractors. All contractors, whether they decided to bid or not, had several concerns with the procurement.

First, despite a great deal of detail provided by the RFP, it left many questions unanswered. For example, it did not specify the scope of the workload to be awarded or the geographic areas to be served. Some potential bidders were reluctant to enter a commitment lacking that information.

Second, the commitment of the government to indemnify MIP contractors for lawsuits resulting from their fraud and abuse activities offers less protection than is currently afforded to carriers and intermediaries under their existing contracts. This was a significant factor in evaluating the economic risk of being an MIP contractor—particularly so for contractors who have experienced the disruption and expense of litigation with parties being diligently investigated for fraud and abuse.

Third, the MIP contracts will not guarantee contractors termination costs. This is a point discussed in more detail a little later in this statement.

Fourth, many companies that were approached as potential MIP partners were reluctant to get involved because of their need to devote all of their available resources to getting ready for the Year 2000.

Fifth, the trend of funding for overall Medicare operations during the past decade caused some potential bidders to doubt that the MIP initiative will be funded at a level sufficient to produce the quality and quantity of work that needs to be done.

On this last point, it is worth noting that while the MIP contracting program is getting underway, carriers and intermediaries are still performing program safeguard activities. Despite the intended stable funding for those activities specified in HIPAA, some contractors have experienced significant cuts in the program safeguard segment of their budgets. In addition to conducting their own program safeguard activities with lower funding, they are also having to devote a very substantial portion of their limited capacity to providing support for investigations being conducted by the Office of the Inspector General and the Federal Bureau of Investigations.

Many carriers and intermediaries are concerned that in the end it will be difficult to prove whether the restructuring of Medicare administration under MIP will really enhance the fight against fraud and abuse. The gradual implementation of MIP could provide an opportunity for an ongoing comparative evaluation between the performance of the MIP model and an adequately funded and better-tuned version of program safeguards as they are now conducted by carriers and intermediaries.

As a final comment on the Medicare Integrity Program, we would like to recommend to the Subcommittee, and everyone interested in controlling health care fraud, a research brief just released by the National Institute of Justice, U.S. Department of Justice. Entitled "Fraud Control in the Health Care Industry: Assessing the State of the Art," this thoughtful review of fraud controls suggests to us the need for rethinking the MIP strategy. This is not to say that MIP should be discontinued, but rather that its heavy reliance on highly automated, large volume, EDP techniques to effectively control fraud is likely to produce disappointing results. A more balanced approach may be advisable.

CONTRACTOR REFORM

For several years the Administration has been recommending that Congress enact its "contractor reform" proposal—an amendment to the Medicare law that would allow it to restructure its contracting process and drastically reconfigure the administrative structure of the program. Among the changes proposed are:

- opening the carrier and intermediary functions to non-insurance companies and awarding all contracts on a competitive basis, but not fully complying with the Federal Acquisition Regulations that other agencies must use;
- removing all statutory restrictions on how various functions now conducted by carriers and intermediaries are clustered;
- abandoning the cost-reimbursement method of contracting; and
- removing the present law requirement that contractors that leave the Medicare program shall be reimbursed for their termination costs.

The “Contractor Reform” contemplated by this proposal is really just a different way of contracting. The argument that contracting reforms are urgently needed in order to permit Medicare to be restructured to meet the challenges of the 21st century, is, to us, something of a red herring.

In the administration of the Medicare program, HCFA already has the power to conduct competitive procurements, but has seldom chosen to exercise that power. It also has authority to contract on an other-than-cost-reimbursement basis, but has been very tentative about doing so.

It is true that when Congress enacted Medicare, it specified that the carrier and intermediary roles were to be performed by health insurance companies. We understand that this was a political decision made in 1965 to satisfy concerns expressed by providers of care and the public about having their health care administered directly by the government. Health insurers were specified because they represented an experienced, qualified buffer between the government and the health care system.

In fact, the health insurer requirement is not much of a barrier to competition. An entity that wants to be a carrier or intermediary merely needs to set up a health insurance subsidiary, or acquire one. Medicare currently has contractors that have followed that route. Having said that, the members of our Committee really have no fundamental objection to opening Medicare to non-insurers, provided the competition is conducted fairly, based upon the demonstrated capacity of bidders to perform the work required.

In general, carriers and intermediaries want to work for Medicare on a for-profit basis. However, we are concerned whether HCFA and its contractors are ready to deal with a fixed-price contract environment in which every substantial operational change would require the negotiation of a contract amendment or formal change order that has to be paid for.

With respect to breaking up the many functions now performed by each carrier and intermediary and packaging them differently with other entities, it should be noted that that is exactly what Congress has authorized for program safeguard activities under the Medicare Integrity Program. We suggest that it would be prudent to wait and evaluate the results of MIP before granting HCFA similar latitude with regard to contractor program management functions.

Under current law, Medicare carriers and intermediaries are entitled to recover their termination costs if they cease to be carriers or intermediaries. The rationale for this provision is that under their cost-reimbursement contracts carriers and intermediaries do not make a profit, nor are they allowed to fund a reserve for the eventual cost of terminated employees. Should they terminate their Medicare contracts and lay off employees, they would be expected to treat those employees the same as if they worked in other divisions of their companies. Yet, those other corporate divisions, which are not limited by government cost-reimbursement contracts, can fund reserves for termination costs as an ongoing expense of doing business. In order to correct this disadvantage under long-term cost-reimbursement contracts, the law provides for Medicare carriers and intermediaries to recover their termination costs.

As I mentioned previously, carriers and intermediaries, generally, would like to operate under for-profit contracts. If they had been operating under for-profit contracts for the past three decades, there would be no need for special treatment of termination costs.

Funding of Carrier and Intermediary Operations

Medicare carriers and intermediaries are proud of their record of steadily increasing productivity. Next fiscal year, they will process more than 900 million claims, provide customer service to over 35 million Medicare beneficiaries and hundreds of thousands of providers of care, support numerous IG and FBI investigations, and handle an increased workload of appeals, inquiries and hearings being generated by our own intensified campaign against fraud and abuse. Once the Y2K crisis is past, we will also be involved in the implementation of numerous provisions of the Balanced Budget Act of 1997.

In its funding request for the current fiscal year, the Administration took the unusual step of stating that, after several years of rising workloads and decreased funding, Medicare contractor operations cannot be reduced further without jeopardizing the best interests of beneficiaries as well a providers and suppliers of care. Yet, in its proposal for the Year 2000, the Administration has reduced the claims processing budget by 8 percent, based upon a projected 1.1 percent reduction in workload.

Frankly, we are skeptical of the Administration's claim that Medicare's fee-for-service claims workload will decrease in 2000 due to growth in the Medicare + Choice program. We also doubt that the proposed overall increase of one third of one percent in the contractor operations budget will provide adequate funding for contractor operations.

The January issue of Health Affairs features an "Open Letter to Congress and the Executive" which addresses the need to provide HCFA with adequate resources to carry out its responsibilities. Speaking of the overall HCFA administrative budget, of which contractor operations is a significant part, it states:

> The latest report of the Medicare trustees points out that HCFA's administrative expenses represented only 1 percent of the outlays of the Hospital Insurance trust fund and less than 2 percent of the Supplementary Medical Insurance trust fund. In part, these low percentages reflect the rapid growth of the denominator—Medicare expenditures. But, even accounting for Medicare's growth, no private insurer, after subtracting its marketing costs and profit, would ever attempt to manage such large and complex insurance programs with so small an administrative budget.

Finally, we are concerned that the Administration has predicated part of the funding of contractor operations upon collecting $93 million in user fees from providers of care who submit paper claims or duplicate claims. These user fees were proposed in the President's Budget for the current fiscal year, but were not approved by the Congress. Unfortunately, their inclusion in the FY 2000 proposal may only serve to confuse the prospects for adequate funding of contractor operations, as it did last year.

WHY CONTRACTORS ARE LEAVING MEDICARE

At present, there are more than 65 Medicare carriers and intermediaries. We understand that HCFA estimates that only about 15 are committed to remain over the next few years. We have no idea whether HCFA's estimate will prove true, but we do know that unless the Medicare contracting environment improves significantly , more contractors are sure to leave. The task of finding replacement contractors and transferring workload to them without disruptions in service to beneficiaries and providers will present HCFA with significant management problems.

HCFA has made no secret of the fact that it wants fewer contractors. Those who want to stay in the program will have to expand. Those who do not regard Medicare as a promising line of business will leave.

Medicare offers no opportunity for contractors to make a profit on their work. The one financial benefit it does offer is that it helps pay its share of corporate overhead. If work is transferred away from contractors, Medicare's contribution to overhead is reduced. Eventually, the decreasing corporate financial benefit derived from participating in Medicare may be outweighed by the many challenges and risks that go with being a contractor.

Some contractors have found that Medicare reimbursement of their operating costs is so inadequate that, even with the program's contribution to corporate overhead, they are subsidizing Medicare operations. Once a thorough analysis of corporate finances reveals this imbalance, a corporation must decide whether it can balance the books by achieving economies of scale or whether there is some benefit to being a Medicare contractor that makes it worth paying the government for the privilege.

Some contractor companies have elected to expand their insurance business to include Medicare managed care products. Rather than attempt to mitigate potential conflicts of interest between the two lines of business—as provided for under the Federal Acquisition Regulations—a few of these companies have elected to terminate their carrier or intermediary contracts with HCFA.

There are two factors that may tend to delay a decision to quit the program. The most important is loyalty to employees. Some departing contractors have been able to spin off their entire Medicare operation to other ownership without any damage to their employees. Others have been able to absorb their Medicare employees elsewhere in the corporation. Until they were able to make these arrangements, they endured the losses from doing business with Medicare.

A second factor is losing the prestige that contractors may derive from being associated with a worthwhile federal social program. However, after years of struggling with increasing Medicare workloads and decreasing resources, that factor, for some contractors, has lost much of its appeal.

Finally, the recent imposition of civil and criminal penalties upon a few contractors has emphasized not only the need for effective internal programs to prevent fraud and abuse, but also the substantial financial risk associated with being a Medicare contractor.

Contractors have all instituted vigorous compliance programs designed to help prevent fraud and abuse from occurring within their Medicare operations. However, should these programs reveal some fraudulent activity, they offer no guarantee against penalties being imposed.

Earlier, I mentioned the issue of contractors recovering their termination costs if they leave Medicare. If legislation that would eliminate that right of contractors begins to move toward enactment, we would expect that action to trigger the rapid departure of a number of contractors.

Mr. Chairman, members of the subcommittee, this concludes my prepared remarks on behalf of the Medicare Administration Committee. Thank you for inviting us to appear today and share with you our concerns about the future of Medicare administration. I will be glad to try to answer any questions you may have.

Chairman THOMAS. Thank you very much, Mr. Boston. Mr. Bryan.

STATEMENT OF DAVID M. BRYAN, VICE PRESIDENT, EDS HEALTH CARE SENIOR MARKETS, PLANO, TEXAS

Mr. BRYAN. Mr. Chairman and Members of the Committee, I am Dave Bryan, vice president for EDS Health Care Services for Senior Markets as well as for our subsidiary, NHIC, which is a Medicare carrier. I thank you for your invitation to testify today.

EDS has served the Medicare and Medicaid Program for over 30 years, nearly since their inception. In 1999, we will process in excess of 100 million Part B claims; provide customer service and outreach services to 2.4 million beneficiaries and 77,000 providers. We will provide data center services processing in excess of 170 million Part B claims, and we will support HCFA's standard Part B system which operates today in 22 States and the District of Columbia.

We believe there are three management and contracting principles that can help meet Medicare's growing administrative demands which will improve service and create better taxpayer value. They are, No. 1, leveraging the Medicare Program's administrative resources to reduce the number of prime contractors to one-tenth the number that exists today; No. 2, value purchasing for Medicare Program management and administrative services must replace a low-cost purchasing decision, and, No. 3, measurable accountability based on objective performance criteria for both contractors and oversight entities.

HCFA has communicated an administrative vision of consolidating Medicare operations onto shared standard systems at fewer sites conducted by a lower number of contractors. We concur with HCFA's strategy and believe it is vitally important for the agency to achieve this vision in order to continue its efforts to improve management of the Medicare Program in a dynamic health care industry and for an unprecedented growth in the Medicare population.

EDS' software was competitively selected to process all Medicare Part B claims as one of these shared systems. We strongly encourage a resumption of the agency's transition to its standard systems. In conjunction with the consolidation of system software, we are also strongly encouraging the consolidation of the number of prime contractors and data centers used to support the Medicare Program taking advantage of existing technology and market capabilities, the Medicare Program can lower its cost, improve the consistency of service, and reduce risk to the program by reducing both the number of prime contractors and data processing centers to one-tenth of that number existing today.

I am not speaking about a brave new world of tomorrow. This environment can exist today with current market capabilities that are ready to be leveraged to the benefit of the Medicare Program. These reductions should be based on objective, quantifiable measures of performance for program managements tasks. It is essential that HCFA define mission-driven, quantifiable performance measures that reflect its strategy and operational goals for the administration of the Medicare Program. Such measures will ensure the agency maximizes the value from its contracting arrangements and will increase the agency's confidence in the accountability of its contractors based on expected results and not best efforts.

Clear expectations for contractors facilitate price competition, increase innovation, and foster improvements within and among contractors. HCFA's purchasing strategies should capitalize on these market incentives by moving away from cost-based contracting to providing partners the financial incentives to bring the best market innovations to bear on Medicare's needs. In the competitive private sector, best-in-class corporations are motivated by being recognized and rewarded for the value they bring to their clients and not on how much overhead expense we can allocate to a single contract.

Mr. Chairman, we, at EDS, understand and have keenly experienced the challenge posed by the upcoming millennium change. Preparing systems for the year 2000 has consumed an enormous amount of time and resources and, quite honestly, slowed progress toward realizing HCFA's information technology goals. However, a consolidated administrative environment will improve the agency's stance with regard to the year 2000 and reduce the risk to the program. It is imperative that HCFA assess and identify in the first quarter of 1999 which of its partners will or will not be prepared to meet the responsibilities of the new millennium. Early identification will allow those partners that are able to support HCFA to have adequate time to effectively increase their assistance to the agency. We believe this approach will attract the right partners to support the Medicare Program and strengthen the program for beneficiaries and taxpayers as it meets its future's challenges.

Thank you again for the opportunity to testify before this Subcommittee and share these perspectives. I look forward to answering any questions the Subcommittee may have.

[The prepared statement follows:]

Statement of David M. Bryan, Vice President, Health Care Senior Markets, EDS, Plano, Texas

Mr. Chairman, members of the committee, I am Dave Bryan, Vice President for EDS Health Care Senior Markets, including its subsidiary NHIC, a Medicare carrier. Thank you for your invitation to testify today and participate in the Health subcommittee's pursuit of a more effectively administered Medicare program. We appreciate the opportunity to share our ideas for meeting Medicare's expanding challenges in such a dynamic health care and technological environment.

EDS has served the Medicare and Medicaid programs for over 30 years, nearly since their inception. EDS's corporate experience currently encompasses a broad range of program management, information technology, and professional services. We deliver these services directly to the Health Care Financing Administration

(HCFA), to a wide array of the agency's partners, including other Medicare contractors and States, and to the beneficiaries and providers served by the program. In 1999, as a Medicare Part B Carrier, NHIC will process over 100 million Part B claims, as well as providing customer service and outreach services to 2.4 million beneficiaries and 77,000 providers. EDS will provide data center services for over 170 million Part B claims and will support HCFA's Standard Part B system, which is currently installed and supporting Medicare beneficiaries and providers in 22 states and the District of Columbia. We understand the essential challenge facing the stakeholders in the Medicare program: to improve services and outcomes within limited resources.

HCFA requires contracting partners that understand and share the vision for Medicare's future as expressed by Congress and the agency. These partners must be capable of delivering on dynamic future needs and able to objectively demonstrate the attainment of defined goals. In today's technological environment, the current cost-based contracting arrangements impede the Medicare program and its contractors from optimizing capabilities and flexibility to best serve beneficiaries and taxpayers. We believe three management and contracting principles can help meet Medicare's growing administrative demands, with improved service, yet at a better value for the taxpayer financed program. They are:

1. Leveraging the Medicare program's administrative resources to reduce the number of prime contractors to one-tenth of today's number;
2. Value purchasing for Medicare program management and administrative services replacing "low cost" purchasing decisions; and
3. Measurable accountability based on objective performance criteria for both contractors and oversight entities.

Leveraging Medicare's Administrative Resources

The administrative structure of the Medicare program has evolved over the past three decades, a time of immense change in the health care industry, the information technology environment, and the programmatic framework of the Medicare program itself. Given the magnitude of these changes, the administrative infrastructure of the Medicare program must be revisited to leverage what already exists in the private sector. The administrative foundation for operating this large, complex, and vital program should not be based on outdated assumptions or left to historical circumstance. Instead, the program's infrastructure should be rationalized, and future partners determined by the quality of their performance and demonstrable contributions to the program's efficiency.

HCFA has crafted an Information Technology Architecture (ITA) vision for the agency and its programs. An Information Technology Architecture ensures that technology supports and enhances business (operational) needs and processes. HCFA's ITA vision includes:

- consolidation of replicated functions;
- "maneuverability" through greater modularity and standardized interfaces;
- greater focus on information, rather than data, to facilitate interactive program analysis; and
- decision support based on reliable and consistent inputs.

EDS concurs with HCFA's ITA vision and is assisting the agency in defining a path to achieving its broad goals. To the extent possible within an environment of significant legislative change and preparing for the new millennium, the agency has taken strides in achieving this vision and continues to pursue elements of this framework. We believe it is vitally important to achieve this vision in order to improve the agency's capacity to meet the challenges of an increasingly dynamic health care industry and to be responsive to the program's stakeholders.

In 1994, HCFA undertook a revision of the Medicare program's administrative environment through its Medicare Transaction System initiative. This initiative sought to build a single claims processing system for all Medicare claims, operating in a significantly consolidated number of facilities. In November 1995, EDS testified in support of the agency's basic vision, while arguing for a flexible, phased approach, based on the principles of risk management and return on investment for the program. The agency eventually segmented its approach to the project, much in line with EDS's testimony, due to a host of challenges. However, the drive to achieve the agency's ultimate goal of consolidation was sidetracked for a number of reasons, including preparing Medicare systems for the millennium change. It remains imperative that HCFA return to its vision of consolidation for all the same reasons the agency initially deemed this necessary to the sound administration of the Medicare program.

Part of HCFA's segmented approach to consolidating Medicare's administrative infrastructure is the transition to standard, shared claims processing systems. EDS's claims processing software was competitively selected to process all Medicare Part B claims as one of these standard, shared systems. We strongly encourage a resumption of the agency's transition to its selected shared systems. In conjunction with the consolidation of system software, we also strongly encourage the consolidation of the number of data centers used to support the Medicare program. Taking advantage of existing technology and market capabilities, the Medicare program could realize lower costs, greater operational efficiencies and consistency, and reduced risk by using one-tenth of the data centers currently being funded by the agency. Additionally, existing technology, knowledge, and capabilities would allow HCFA to reduce the number of Medicare Part B contractors to one-tenth of what is being used today, creating even greater cost reductions, operational efficiencies, and consistency in program administration. What I am speaking of is not a "brave new world." In fact, the environment I refer to exists today and is ready to be leveraged to benefit the Medicare program, reduce risk for the program, and improve the service we provide to beneficiaries and other stakeholders across the nation.

Mr. Chairman, we understand and have keenly felt the challenge posed by the upcoming millennium change. Preparing systems for the Year 2000 has consumed an enormous amount of time and resources and slowed progress toward realizing HCFA's information technology goals. However, a consolidated administrative environment with well-prepared, committed partners will improve the agency's stance with regard to the Year 2000 and reduce the risks to the program. It is imperative that HCFA assess and identify in the first quarter of 1999 which if its partners will or will not be prepared to meet the responsibilities of the new millennium. Early identification will allow those partners that can help HCFA achieve a smooth transition into the new millennium ample time to provide the agency this assistance.

There is no doubt that the health care and technology environments have changed fundamentally over the past three decades, thereby demanding that a new and revised skill set for managing the Medicare program be established. Legislative and regulatory changes along with these industry trends have only increased the necessity for more flexibility and agility in meeting Medicare's administrative needs. HCFA can capture economies of scale and access new sources of innovation and expertise by redefining its contracting partnerships. But partnerships for the new millennium must be based on specific capabilities and objective performance that meet evolving program needs. It is incumbent upon HCFA to continue to: identify these needs; seek assistance from industry leaders in developing fair performance criteria for meeting these needs; objectively measure performance among all its contracting partners; and foster open communication among all partners to share successes and improve service across the Medicare program.

VALUE PURCHASING

Another essential principle in improving Medicare's administrative effectiveness involves purchasing decisions based on value rather than the short-term allure of low cost. Low cost administrative purchasing practices can often create a higher total cost to taxpayers and reduce the quality of services provided to beneficiaries and other program stakeholders. Medicare's program management expenditures must be treated as public investments aimed at achieving clearly defined operational standards and outcomes. Administrative value must be defined by the quality of service delivery and the level of protection provided to the Medicare Trust Funds, as well as by the unit cost of services. Cost-effectiveness is not driven solely by price or unit costs, but also accounts for the efficacy of purchased services in accomplishing desired program outcomes. When the balance between cost and outcomes is not attained, both the results and cost of the program lose taxpayer confidence. When the balance is achieved, the program operates at the highest level of efficiency.

We support HCFA's stated goal to be a prudent purchaser of health care services on behalf of the public. In the administrative area, prudent purchasing demands a clear, objective expression of expectations and operational standards so that program goals can be mutually understood and met by contractors. The application of standards and measures must be consistent across time and geographic areas. Without such clarity and consistency, program management funds might be ineffectively prioritized and misallocated toward competing needs, wasted in pursuit of undesired ends, or overspent towards ends that are already met and exceeded but left unmeasured.

Clear expectations for contractors facilitate price competition, increase innovation, and foster improvements within and among contractors. The incentive for contractors to expand their participation in the Medicare program drives them to meet and surpass defined goals. Everyone involved with the program benefits from such competition to grow business through better service and program savings. HCFA's purchasing strategies should capitalize on these market incentives to improve service, increase efficiency, and expand program participation by moving away from cost-based contracts to providing partners the financial incentives to bring the best market innovations to bear on Medicare's needs. In a cost-based contracting environment, only the government is motivated to find cost reductions. Cost-based contracting insulates the Medicare program from the best technology and professional services that industry has to offer in pursuit of higher productivity and higher rates of return. In the competitive private sector, best-in-class corporations are motivated by being recognized and rewarded for the value they bring their customers and not how much overhead expense can be allocated to a single contract.

We are aware that Federal budget rules treat discretionary administrative and entitlement benefit dollars differently. But the total amount of tax dollars available to fund benefits can be significantly increased by providing adequate resources to purchase the best administration of Trust Fund benefit dollars. Given the magnitude of the public resources at stake in the Medicare program, and the relatively small percentage paid for administration, the Congress and HCFA could extend Trust Fund resources and capture savings if they treated administrative expenditures as investments. Value to program beneficiaries and taxpayers is not realized when outlays are incurred, but rather when high quality services are delivered and desired program outcomes are achieved.

MEASURABLE ACCOUNTABILITY

All Federal agencies have begun to shift focus toward measurable outcomes in pursuit of the statutory requirements in the Government Performance and Results Act of 1993. We believe that HCFA will better achieve its own Annual Performance Plan goals to the extent it projects this framework into its contracting arrangements and partnerships.

It is essential that HCFA define mission-driven, quantifiable measures that reflect its strategic and operational goals for the administration of the Medicare program. EDS's work with other federal agencies has proven the power of this approach. Such measures will ensure that HCFA derives maximum value from its contracting arrangement and will increase the agency's confidence that its partnerships are centered around shared understandings and expected results, as opposed to best efforts.

Several ongoing, operational benefits will also accrue from defining objective, quantifiable measures, in addition to reaching desired program outcomes. The process of developing and monitoring performance measures will structure and facilitate open and clear communication among HCFA and its partners. Improved communication will increase the extent to which different entities understand the challenges and risks facing each other. In addition, such an environment will identify areas where HCFA perceives conflicts of interest within and among its partners. With better identification, such areas can be mitigated or corrected more rapidly. Similarly, with the ever-increasing emphasis on assuring the integrity of the Medicare program and its administrative structure, these performance measures will clarify the roles and responsibilities of all parties involved. We believe strongly that a program as large and complex as Medicare can only achieve the efficiency, effectiveness, and integrity necessary to sustain the trust of its beneficiaries and the taxpayers when roles, responsibilities, and expectations are clearly defined and measured.

In conclusion, as the infrastructure of Medicare is revisited in light of new priorities and a new environment, it is essential that the oversight focus of Medicare operations rest on the content and quality of program management tasks and performance. Many diverse skills and capabilities make up the pool of expertise necessary to effectively administer the Medicare program and this array of needs will continue to evolve. Building the capacity to define specific outcomes, measure results, and allocate resources most effectively is of primary importance towards these ends. We believe this approach will attract the right partners to support the Medicare program and strengthen the program for beneficiaries and taxpayers as it meets its future challenges.

Thank you again for the opportunity to testify before the subcommittee and share these perspectives. I look forward to answering any questions the subcommittee may have.

Chairman THOMAS. Thank you very much, Mr. Bryan, for your testimony. The gentlewoman from Connecticut wish to inquire?

Ms. JOHNSON of Connecticut. Yes, Mr. Bryan, I find your testimony very interesting, and I will read it at more detail in the future, but I am concerned by your belief that it can all be so clearly defined. In the past, we have had to use best effort, because often the regulations were not out; it wasn't clear what the law was; we were operating by letters of direction; those letters often change; they sometimes even reverse themselves. So, I think you have to be careful about believing that, in essence, we can blame it on the contractors, particularly in this sort of brave new world of the Inspector General and audit resources. You saw what happened when the Inspector General came in using inappropriate, outmoded, inaccurate standards in the medical schools of the country and made medical schools look like criminals for doing what they had been specifically instructed to do. So, I am worried about that.

The second thing that I find very concerning about your testimony is this idea of having a few very big ones. Well, we went through that in Connecticut, and we went from Connecticut-controlled to Maine, and I will tell you, it wasn't easy; it hasn't been easy; it never has been easy. And we are having problems with a Connecticut contractor now, but we want another Connecticut contractor. I don't know that—I understand that information management cuts costs and the bigger the better, but there are also complicated systems, the regional variations, and reimbursement rates and all those things, and I think we run a tremendous risk of trying to have too few centers, and I would rather get things running smoothly and not have Maine try to remember all of the variations that happen in Connecticut and all the variations that happen in other States. So, I am concerned about those two aspects of your testimony, and if you have a brief comment, I do have a question also for Mr. Boston.

Mr. BRYAN. I believe that as we look at the consolidation of contractors, to the extent that data can be consolidated, consistency can be created in the programs and into the processes. Consistency creates a better view for the Medicare beneficiaries and the providers to work with the programs.

Consolidation does not necessarily mean that you wouldn't have support centers in each of the States or at a local area that would assist for the local needs of the beneficiaries and understanding what that community has to offer.

At the same time, we believe that what technology can bring and create—what we would call—peak performance in terms of the number of claims processed creating maximum efficiencies, that the economies of scale that it would bring to the program in administrative funds as well as reducing the number of oversight individuals required by the agency to oversee such a large number of contractors, this would free up resources financially as well as HCFA staff to move to other areas of the program such as the Balanced Budget Act or HIPAA.

Ms. JOHNSON of Connecticut. See, I really disagree profoundly with that point of view. Rate setting now and oversight of rate paying varies so much from one little hospital to the next little hospital; a little tiny nursing home to a bigger nursing home. I mean, this is not easy, and there is a big advantage to having your payer know the territory and know the variations, and there is no way a regional administrator can know this; they just literally can't. And when we have something go wrong, it goes wrong all over the place.

So, I personally think—I have not yet seen—let us put it this way—I have not yet seen a technology system in HCFA function well enough to want it to be spread across the region, and I would have no confidence in a regional center. So, maybe down the road apiece, but I say let us get the thing operating right; let us get the reforms made; let us get the regulations written, but don't jump to bigness.

Look at what is happening in all the mergers in managed care; they are having trouble. Why? Because health care is very local, and I think—I had one big provider say to me, "We will big provide certain kinds of things, but in every area there are going to be small plans, because you can't do it from the bigness. You can do certain things; you can't do others." We are always going to have fee-for-service medicine in rural areas, because you can't do managed care everywhere.

So, I am not at all comfortable with the position you are taking, but I don't want to belabor that point.

I do want to ask Mr. Boston a specific question: HCFA has made some efforts to reach out to hospitals and doctors and medical equipment providers and press them on being prepared for Y2K—there are 1.25 million providers. Do you see their efforts as being successful? Are they doing enough? Should they be doing more? Are they concentrating too much on the big providers and not enough on the little guys out in the sticks that really need help or at least reminders?

Mr. BOSTON. Mrs. Johnson, I believe that HCFA and its contractors are working very closely together to try to accomplish that notification. Where HCFA may be meeting with the national organizations, we as contractors are meeting with many of the State organizations and the local organizations to try to get the word out, and I think it is a very concerted effort of both parties to try to get the word out. We are very worried that people understand the complexity, and we find that, particularly the smaller medical care providers, don't understand the problem and need our help.

Ms. JOHNSON of Connecticut. Right. Well, I am glad to hear that you are meeting with them. I mean, it is a better effort than we have been making. Are you prepared, though, to handle paper claims if there are problems with Y2K?

Mr. BOSTON. We believe that we are prepared to handle an increase in paper claims, although I don't believe that that is what we are going to see. Most doctors' offices, clinics, other kinds of providers these days use computers in generating their records and their claims. My belief is if that computer system is not millennium-ready, it won't be able to generate a paper claim, electronic claim or anything else. And what a more likely scenario will be is that the provider simply won't be able to bill the Medicare Program for some period of time. Now, with HCFA, we are working on strategies to prepare for a probability of some providers not being able to bill, but, again, I don't believe that we are going to see a tremendous increase in paper.

Ms. JOHNSON of Connecticut. Interesting, thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. Does the gentlewoman from Florida wish to inquire?

Ms. THURMAN. Thank you, Mr. Chairman. Ms. Gagel, let me ask you a couple of questions, because I noted in your testimony that you said that we don't need any contractor reform. But let me ask you this, because you have been on both sides: What could you offer to this Committee that would give us an indication or that would help HCFA evaluate these contractors, better than what we are doing today? I am just curious.

Ms. GAGEL. I think that—and I found the questioning of the Committee members to the administrator very insightful—I think the most important thing that we all need to do is understand what is going to be needed in Medicare administration in the future. We know the program will change. When the program changes, presumably, the administration of the program needs to change, and it seems to me that the first thing we need to do is to understand what that administration needs to look like and act like and feel like. I think, probably, most people would suggest it doesn't need to look like what it looks like now which is what it has looked like, in one way or another, for 30 years, but to move to specific proposals in the absence of a dialog and a clear articulation of goals and a strategy for Medicare administration, is actually what is concerning, I think, probably more than anything else.

There is some agreement on some of the tactical things, standard systems, for example, and the fact that that does improve program administration in terms of making it certainly more reliable; reducing error rates; making it more efficient, more economical. There is general agreement on that kind of thing, but if the focus is going to be on improving services to the elderly population in this country which is clearly one of the goals that the Health Care Financing Administration is articulating, you aren't going to want that customer service to look like what Medicare contractors do today, but we haven't really articulated what it does need to look like and who needs to be providing that service.

Ms. THURMAN. But also in your testimony you say that HCFA has this authority to replace or not renew their contract on poor performance. The problem is—and I guess where I am trying to figure out—is how do we figure out what that poor performance is? And, for example, in the Inspector General they said, "Nine of the eleven contractors with audited financial ledgers could not support the accounts receivable. There is little assurance that amounts eventually paid to providers through the final cost report settlement process meet Medicare guidelines for reasonableness and appropriateness."

So, it seems to me, there are two things going on here, then. I mean, in one sentence we are talking about we could just let them go for poor performance, whatever that means—and I am trying to figure out how we put a standard to that—but at the same time, I understand the direction issue of the kind of direction that we need to be given, but there seems to me that there ought to be some way to pull those two things together. Because contractors need to know what is going on out there in their lives too, so if you do contractor reform and you have a working relationship and you know what your job is and you know what we are expecting from you and you know what potentially puts you in a situation of not having a renewable, I mean, somehow there has got to be a way to work through this, and it sounds to me, from what I can gather, the system today is not happening that way.

Ms. GAGEL. The standards have—the expectations, if you will—with the exception of Y2K, where HCFA is very clear in its expectations—have I think, indeed, become more murky over the years. We know, for example, that we have to be very efficient; that efficiency becomes a negotiating tool.

But we have a hard time understanding with the exception of "do a lot of it" what the expectation of the Health Care Financing Administration really is. We have a hard time talking about understanding results, and that is the dialog I think that needs to take place.

Ms. THURMAN. Some of that is not just HCFA. I mean, some of that is just us, too, changing things constantly around and trying to put in new rules, and, obviously, we have gone through a very difficult time, because we have tried to balance the budget and we have, but the fact of the matter is, I mean, there are things we are doing as well. So, we couldn't just——

Ms. GAGEL. One of the things that we are working on in other parts of our program—and, indeed, we are working with this with the Medicare contractor also—is establishing a very tight system of metric, so that we can understand what we need to do to be successful in health care compared to all of our competitors. There isn't any reason why we wouldn't want to do that; why HCFA wouldn't want to do that for Medicare contractors also—establish the metrics; measure yourselves against both the private sector and in our case other Medicare contractors so that expectations become very clear. There is a tremendous discipline involved in doing that, and it provides tremendous focus for the people involved in it.

Ms. THURMAN. Actually, that sounds like a little bit of reform there to me. Thank you.

Chairman THOMAS. My understanding is the gentlewoman from Connecticut has another question that she really wants to ask.

Ms. JOHNSON of Connecticut. I appreciate your experience in the system. I try to keep extremely close touch with the system out in the real world, and I just wondered if, from your perspective, do you think the system can tolerate the cuts in spending in the President's budget?

Ms. GAGEL. In the budget for the year 2000? We are still analyzing the budget and have not yet taken a position on that. We are concerned, of course, about the user fees, and I know that we testified to the Committee about that last year and were pleased that they did not go forward.

Again, I think it depends on expectations. As Mr. Boston said, I think, with regard to the year 2000, funding is adequate unless contingency planning, testing, becomes—particularly with regard to working with providers—end to end testing becomes a much greater expectation than we expect it to be right now.

I think if you really want Medicare beneficiaries in this country to understand the Medicare Program—how to access the benefit; how you use the benefit wisely, are we funding that in this country? I think not now. I suspect in years to come we will, because the demographics of the population will kind of require it, I suspect, but—so, again, it depends on what your expectations are.

Ms. JOHNSON of Connecticut. Mr. Boston.

Mr. BOSTON. Yes, if I can respond on behalf of the Medicare Administration Committee, we are very concerned about what we think is in the budget for the year 2000 and some of the cuts that are there if, in fact, the operational requirements remain as they are today. We are——

Ms. JOHNSON of Connecticut. You mean, if they don't get bigger or if they stay the same? You wouldn't be concerned if they got less?

Mr. BOSTON. Well, if the requirements put on us are in line with the money available, then it is not a concern.

Ms. JOHNSON of Connecticut. Is that true now?

Mr. BOSTON. It is always a very difficult goal to hit HCFA's targets. We did a great many changes throughout the year, and most of them say do it within your current budget; we are all quite used to that.

Ms. JOHNSON of Connecticut. Well, you have some formidable challenges ahead of you, some of the very biggest with BBS for home health and outpatient and stuff, and, frankly, the resources aren't that much greater, so I would assume the answer to my question is really, no, that the resources don't appear to be adequate.

Mr. BOSTON. We are going to be very interested in seeing how that budget progresses and what changes are made. We are very concerned as it is presented that it might not have sufficient resources, but we also know that the initial budget presentation, the final budget, there is a great deal of work in between and an opportunity to make our concerns known.

Mr. BRYAN. I would like to echo one item presented by Ms. Gagel and that is that we are concerned about the level of funding for communication and outreach to the beneficiaries. With such rapid change, we have only seen decreases in those areas, and we think that that is an area that should be increasing, because beneficiaries have many questions. It is not easy to understand the new Medicare information and there is going to be a greater demand on our resources as someone mentioned earlier to spend time on the phone with the beneficiaries and to go out into their communities and to put on seminars.

The other component that we are concerned about is as we move toward the Program Safeguard Independent Contractor, in MIP, we will see an increase in the number of appeals and requests for reviews on those programs, and so we are concerned about that level of funding. All of this I would center around the communications and the interaction with the beneficiary communities.

Ms. JOHNSON of Connecticut. Well, I would urge you as you analyze the budget to assume that the fees won't be passed; that is just a new tax source for what should be administrative costs. I think you should look back at the past when the fees were not pressed by either—members from either side of the aisle, and I would say that if other members are seeing what I am seeing out there, and what I have talked to MEDPAC about, the case for cutting reimbursement to hospitals can't be made.

So, I would say there are lot of cuts in that—I don't see any so far that are going to survive, and if that is the case, then we have a big budget problem, because, of course, those savings were used to fund new spending elsewhere in the budget. So, we are in very serious circumstances; many, many promises have been made, and it is unfortunate that some of them have been made on the basis of savings that can't be realized, and we look to your help to be as realistic as you can with us but also to be willing to stand and say this can't be done. Thank you.

Chairman THOMAS. Well, thank you for your testimony. Both the Ranking Member and I have written HCFA with concerns about the suggested shift toward MIC. I have a hunch that maybe it will be about as successful as the user fees in other areas. It just, at the current time, does not seem like an approach that makes a lot of sense.

Part of the tension that I hear in terms of this discussion is that you are talking about wanting to try to deal in a market-based world with an administered price animal, and that is always going to be conflicting. And that is one of the reasons, of course, the Medicare Reform Commission is looking at trying to make some changes which would provide beneficiaries the kinds of services in a world in which many of these decisions that are now made laboriously through a bureaucracy with administered prices in a box called market, because we find out it works very well and there are compensations that take place.

Mr. Boston, I said that your testimony was interesting, and, Mr. Bryan, I would like a reaction to it, because you described the way in which some of the carriers and contractors got started, because they had to be licensed insurers as though that is some kind of a hurdle or a requirement that produces some level of competency or certifiability. How hard is it to get over the hurdle of being a licensed insurer, and does it mean anything anymore? Anybody?

Mr. BRYAN. I would say for us——

Chairman THOMAS. Well, I know you have got a whole bunch of contracts, and I understand you are trying to be a licensed insurer in California.

Mr. BRYAN. NHIC is actually approved by the California Insurance Commission to administer the Medicare program in California.

Chairman THOMAS. So, you were a shopper; you are now a buyer, so you are a—did you buy an insurance company?

Mr. BRYAN. No, we actually had one that we had never utilized before in the Medicare Program. We only utilized the insurance subsidiary to help with our Medicaid contracts.

Chairman THOMAS. How did that make you a better contractor?

Mr. BRYAN. Quite honestly, I don't think it did. What I think did make us a contractor was the picking up of the staff and the knowledge capabilities from the workload that we assumed, and we pulled forward a very knowledgeable work force. What we brought into place were different management practices to create the efficiencies we thought we could bring to the program.

Chairman THOMAS. And that is the kind of market-based, bottom-up structure changes that I think simply have to take place instead of the discussion that took place previously.

Mr. Boston, you made some fairly provocative statements as far as I am concerned, and I alluded to them earlier where invariably in one of these hearings with whoever the administrator happens to be to extol the virtues of the administrative cost structure of HCFA versus the outside world—and that somehow they are always half of what goes on in the private sector—but you indicated that you thought that there was and has been a degree of subsidy going on among contractors. Now, the big bucks, I assume, are over with the Blues, and maybe I am wrong; you are kind of representing the non-Blues—whatever the rest of the color spectrum is, it is not blue. Has anybody ever looked at attempting to quantify this or is it such a variable over time or in certain circumstances that you know you do it, but it is difficult to show? Or by the time people show they are out of it because they realize they were doing it and couldn't stay in business because they did?

Mr. BOSTON. I think it has been far more anecdotal, Mr. Chairman, than studies. We have heard from people who, in some cases, have pulled out of the program that the amount of money HCFA was willing to give them to perform the administrative services was no longer covering their costs, and in some cases they had elected to use corporate funds to make up that difference. How a company chooses to do that is certainly a business decision they make. I can tell you that the board of directors I report to at WPS have given me a very clear indication that we will never subsidize the program. We will certainly do it at a very efficient cost, but we won't contribute private subscriber funds to do that. But some have; some have gotten out; some may continue to.

Chairman THOMAS. Ms. Gagel, I saved you for last, because clearly the pitch—and I really do appreciate the testimony; we are going to bring you back as we begin to look at some of the administration's suggested changes when they firm up and we have the ability to have a programmatic discussion—but you are interesting to me, because, as the gentlewoman from Florida said, you have been in the structure and you are now outside the structure, and you were in a responsible position. The whole MTS situation, as comfortable as you are or to the best of your ability, how in the world—I mean, when I first took over, I was wheeled over to Baltimore, and they brought out all these charts to show me the solution for tomorrow and that all of the problems that I was concerned about and others were concerned about, including indigestion—— [Laughter.]

Chairman THOMAS [continuing]. Were all going to disappear once this MTS was put in place. And then like 4 months later I find out that at the time that they were informing me about this wonderful new change, they were pulling the rug out from under it as well or they were coming to the realization that it just wasn't going to work. What happened?

Ms. GAGEL. I could only, I think, probably, speculate on what happened. I was involved in the very early planning, the conceptualization, of what turned out to be MTS, and the conceptualization of that was, indeed, some of the things that were talked about earlier: the need for HCFA to have systems that it controls that are predictive of payment. That was essentially what MTS was all about; to have HCFA control the claims processing operation rather than have 10 or however many systems around the country do that. That was a very important thing. The other thing we were looking at was looking forward to the day that the Medicare Program would change. The systems in Baltimore are fairly antiquated. If indeed as you are now going to Medicare Plus Choice and will not only have a fee-for-service option but beneficiaries might also have PPO options and HMO options, we felt that the systems at HCFA could not in any kind of an efficient way recognize all those options and be able to pay claims.

The other thing the systems cannot do today and that we as Medicare contractors cannot do—and the CFO, the Inspector General, study that was released yesterday points this out very well—we can still not aggregate data so that we are looking at data from the beneficiaries' point of view. If you look at what the Inspector General study does, it looks at claims paid for a beneficiary over a 3-month period of time, and in hindsight we can all do a real good job of deciding what was necessary and what was not and knowing that you don't pay an outpatient bill if somebody is really in a skilled nursing facility and stuff like that. We could do a lot of that on the front end if we had the computer systems that permitted us to do that or simply the data warehouses that would collect the data, and that is really what MTS was all about. Obviously, there were management issues with it, and that was very unfortunate, but some of the conceptual design is, I think, probably still where HCFA needs to go and will probably end up going at sometime in the future.

Chairman THOMAS. But to me it is almost an example of what happens when you try to create a front-loaded resolution of an administered-price system. You just can't do it, and that is one of the beauties of the ability to adjust that in the marketplace and why the Medicare Commission is looking at a prospective payment system for that area of HCFA. Now, clearly, in the old-fashioned, if you will, fee-for-service which is still 85 percent of the folk, we have got to figure out ways to get some of the benefits changed like putting prescription drugs in, and that if we are going to have to live with administered prices, we are going to have to clean it up so that the decisions can be made more transparently.

We all draw from our own analogies, and I just noted in the news the other day that a company in the automobile industry that is considered fairly efficient in management is the BMW company, and they acquired the so-called Rover Group from England, and they thought for particular amounts of money they could breathe life into it, and, as a matter of fact, the top management position at BMW bet his career on it. He recently resigned, because it did not do it in the timeframe and for the money they thought it was going to do.

One of the real frustrations I have with our dealing with HCFA in the current system, to me, is that MTS in the health care area is analogous to the Rover Group with BMW. I know the administrator left; he got out of town. Inside that structure, there were obviously some folk in important administrative positions whose responsibility it was to make this happen and that it didn't, and it has caused all the problems that we are in now with Y2K and the rest. To your knowledge, are these folks still in their positions? Did any heads roll over this?

Ms. GAGEL. I have been away from HCFA too long, I think, to be able to make an assessment of, frankly, whose head should have rolled, and so I really can't respond.

Chairman THOMAS. I tell you, Ms. Gagel, we have investigated, and the fact of the matter is virtually no heads rolled and certainly the ones who should have rolled didn't. It is one of the frustrations with a bureaucratic structure with administered prices, and that you folks in the world that you, in interfacing with that world, have got to change.

Ms. THURMAN. Mr. Chairman.

Chairman THOMAS. And as we go through with these programmatic changes that are being offered by the administration, we are going to want your input to evaluate them vis-a-vis other models or options so that we can make the best decision possible in reforming the very needed reform area of the bureaucracy interfacing with contractors.

The gentlewoman from Florida.

Ms. THURMAN. Are you—I am just asking because I don't know—so, none of the folks that were involved with this are—they are all still there? Are these civil servants or were—I would imagine the civil servants could still be there, but were the top officials—I mean, at least one of those we know is gone. I mean what about the rest of them? Are they still around?

Chairman THOMAS. I would love to visit with the gentlewoman on the scenario of what happened on something as fundamentally failing as the MTS system and the—first of all, why do you put something at the absolute core? You have got all of your eggs in that particular basket and then not have a fallback position.

Ms. THURMAN. When did that happen?

Chairman THOMAS. That happened in——

Mr. BRYAN. It was toward the end of 1996 and early 1997.

Chairman THOMAS [continuing]. 1994, because it was just——

Ms. THURMAN. That was when the system was bought?

Chairman THOMAS. No, no, no. It was being developed. It was going to be—the rollout was eminent. When we became the majority, I went over there to get my information, and Bruce Lattick had everybody come in and talk to me about this new program when at the very time they knew that it wasn't going to work. January, 19——

Ms. THURMAN. But the development of this had been going on before.

Chairman THOMAS. It had been going on for a long time. Ms. Gagel, can you help us on that?

Ms. GAGEL. Well, I left that part of the organization in 1992, and it was in the late conceptual stages at that time, and we started a year or two before that.

Ms. THURMAN. So, it has been going on for a while, OK.

Chairman THOMAS. Oh, yes, it went on for a long time. They put all their eggs in that basket.

Ms. THURMAN. Thank you.

Chairman THOMAS. And, actually, maybe we will do a head count.

I want to thank you very much and look forward to your input. I hope it is as honest and frank as your written testimony was today.

The Subcommittee stands adjourned.

[Whereupon, at 5 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the American Medical Association

The American Medical Association (AMA) appreciates the opportunity to submit this written statement for consideration by the Ways and Means Subcommittee on Health and requests that it be included in the printed record.

The American Medical Association believes that Congressional intervention is needed to correct management problems at the Health Care Financing Administration (HCFA). These problems have been building up for many years. An ill-advised reorganization and a heavy workload from requirements of the Balanced Budget Act of 1997 (BBA) have overwhelmed the agency.

Consider the following examples:

- Three primary care physicians in Idaho Falls, Idaho, recently felt compelled to stop treating Medicare patients altogether in the wake of an overzealous and overly punitive effort by the local Medicare carrier to recoup thousands of dollars in payments due to differences of opinion about appropriate coding and documentation. A number of the disputed claims were for laboratory tests, which is all the more outrageous because, at the same time the carrier was making its recoupment demands, HCFA was engaged in a negotiated rulemaking process to determine what rules should guide its administration of Medicare's lab test benefit. Rather than face the prospect of civil fines of up to $10,000 per clerical error or billing mistake in the future, prosecutorial zealotry, and the associated legal costs, the physicians simply decided to discontinue their involvement with the Medicare program.
- While 85% of Medicare beneficiaries remain in the fee-for-service program, conflicting HCFA priorities and a high attrition rate among experienced staff have led to serious problems. For example, in setting the Sustainable Growth Rate for physician services, as required by the Balanced Budget Act, HCFA significantly underestimated Gross Domestic Product growth for 1998 and enrollment for 1999. So far, HCFA has made no effort to revise its estimates to reflect more up-to-date information. Physician payments for 1999 have already been underfunded by about $645 million due to these projection errors, and HCFA's continued use of the erroneous estimates could lead to steep payment cuts as soon as next year.
- In testimony before this Committee in January 1998, the General Accounting Office described numerous deficiencies in HCFA's oversight of its claims processing contractors, using as an example the region that formerly had six staff dedicated to contractor oversight but now has only two. This lack of oversight has allowed the Part B carriers to get away with establishing local coverage policies that parallel abuses of some managed care organizations:
  - In some localities, claims for the physical evaluation necessary to clear patients for anesthesia and surgery are being denied as noncovered because "Medicare does not cover screening services."
  - Similarly, it is standard clinical practice in urology to give a man who complains of lower urinary tract symptoms a PSA test, but in many localities patients have no idea if the test will be covered because carriers will not pay for the test if the diagnosis turns out to be enlarged prostate. When administered to diagnose lower urinary tract problems, the PSA test is clearly not a screening test.
  - Virtually no effort is made by the carriers to inform or educate physicians about Medicare's coding, payment, and coverage policies, nor are they provided with meaningful appeal options once the carrier has decided a problem exists.

- Often, carriers themselves have little knowledge of appropriate coding practices. In one case, a carrier attempted to recoup more than $80,000 from a physician, but after the physician persistently and relentlessly sought a reevaluation, the amount owed was suddenly reduced to $2,000. In another case, during the audit process, the carrier auditor made written notes and verbal comments demonstrating he was unaware of the existence of the ICD–9 code book.

We believe that HCFA's problems will only get worse as the number of Medicare patients, claims, and health care delivery systems increase. To say that HCFA's current problems could lead to a crisis is an understatement.

The AMA believes that a crisis exists, and that this crisis is beginning to spill over into the actual delivery of health care to our nation's Medicare patients.

We believe that HCFA is currently traveling down the same road the Internal Revenue Service (IRS) was on before Congress heeded the demands of taxpayers and forced the IRS to restructure its policies. Just as the IRS is struggling to reinvent itself into a "customer" friendly agency, HCFA must, with a push from Congress and the Administration, reassess its role and relationships with medical professionals who care for Medicare patients.

Further, there is a growing sense among Medicare experts that HCFA is ready to collapse under the sheer weight of its administrative duties. This sentiment was clearly stated in a January/February 1999 Health Affairs article co-written by several of the nation's leading health economists, including three former HCFA administrators: "The mismatch between the agency's administrative capacity and its political mandate has grown enormously over the 1990s. . . . HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse has been increasingly compromised by the failure to provide the agency with adequate administrative resources." The AMA shares these sentiments and believes that HCFA needs additional resources to meet its continually expanding statutory requirements.

The AMA commends Congress for holding hearings last year to assess HCFA's initial implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104–191), and the Balanced Budget Act of 1997 (BBA) (P.L. 105–33). However, many issues remain. We implore Congress, and particularly this committee, to hold additional oversight hearings to assess:

- the overly burdensome regulatory requirements placed on physicians, hospitals, and other health care providers;
- whether HCFA has remained within its statutory authority in the rulemaking process;
- HCFA's failure to distinguish inadvertent billing errors from intentional acts to defraud the government;
- HCFA's ongoing implementation of the Medicare+Choice program;
- the process HCFA utilizes to draft rules and regulations;
- HCFA's process for considering and responding to public comments on its rules and regulations; and
- HCFA's oversight of Medicare carriers and other contractors.

Beyond the critique of HCFA that will be provided by the General Accounting Office, Congress should consider the many ways in which HCFA's regulations for administering Medicare and Medicaid affect virtually every physician, hospital, and other health care provider in this country and their ability to care for Medicare and Medicaid patients.

The AMA also urges Congress to hold hearings to address the following critical issues:

Improving Medicare's SGR System

HCFA's mismanagement has had a deleterious effect on the Medicare fee-for-service (FFS) program as well as the more frequently discussed Medicare+Choice program, and the Sustainable Growth Rate (SGR) provides a good example. The SGR is a target rate of spending growth. Cumulative actual spending is compared to cumulative target spending, and payment updates are determined by whether actual spending exceeds or falls short of the target amount. The target is based on annual changes in: inflation, Medicare FFS enrollment, real per capita GDP, and spending due to law and regulation.

HCFA established a 1999 SGR of −0.3%, which became effective October 1, 1998 for fiscal year 1999. This *negative* growth target means that, unless total FFS physician spending is less in 1999 than it was in 1998, next year's physician payment update could actually result in a payment cut. A key HCFA assumption underlying the negative SGR is that the number of beneficiaries enrolling in Medicare+Choice plans will grow by 29% in fiscal 1999. With the recent HMO withdrawals from

Medicare, this assumption seems seriously overstated and obviously erroneous. In fact, the rate of increase in managed care enrollment has been declining since July, and the most recent monthly data show an actual decline in managed care enrollment.

HCFA has already made one significant error in setting the first SGR for 1998. In October 1997, HCFA projected 1998 GDP growth of 1.1%, but 1998 GDP growth is now estimated to have been at least 2.8%. When combined with other, smaller projection errors in the 1998 SGR, HCFA made a net underestimate in the 1998 SGR of 1.5%. With Medicare spending on physician services currently at about $43 billion annually, the projection errors led HCFA to set the payment update for 1999 about $645 million lower than it should have been.

HCFA has acknowledged the projection error problem, stating that, "[w]hile we will use our best efforts to make estimates at the time the SGR is established, we are concerned that there will be differences compared to later estimates of some of the components of the SGR." In one regulation, HCFA also stated the errors would be corrected: "[d]ifferences between projected and actual real gross domestic product per capita growth will be adjusted for in subsequent years." But to date, HCFA has not revised its estimates to reflect the more accurate, updated information.

Because the SGR system is cumulative, if left uncorrected, projection errors will be compounded with each year's payment update calculation. To have the cumulative SGR become merely an accumulation of erroneous HCFA estimates would defeat the whole purpose of the spending target system. The level of underfunding of Medicare physician services due to these errors could grow to the $1–2 billion range as early as next year.

Program Integrity

The AMA is very concerned about HCFA's overly zealous implementation of its policies in addressing waste, fraud, and abuse. The Administration continually fails to distinguish between "genuine" fraud (knowing and willful) and legitimate billing issues, i.e., differences in medical judgment over one level of coding. There is a vast continuum of issues arising in Medicare claims (e.g., deficiencies in documentation, inadvertent coding and billing mistakes, intentional criminal fraud, etc.) that HCFA constantly lumps together in the catchall category of waste, fraud, and abuse. To date, HCFA has essentially taken a single approach in dealing with a whole range of problems.

HCFA's sole response to a broad range of complex problems has been to address each one in an aggressive and punitive manner. The blurring of the lines between waste and fraud has tremendous implications for HCFA's policies and programs, not to mention for physicians trying to follow all the rules to comply with the program. In response to the current environment, carriers are forced to pursue aggressive tactics. In this "gottcha" environment, both patients and physicians suffer.

Physicians want to provide quality care for their patients without running afoul of HCFA's labyrinth of complex and burdensome requirements. We have received numerous reports that carrier feedback is severely lacking. The AMA has repeatedly urged the Administration to increase its educational efforts to individual practicing physicians who may not be aware of their honest and inadvertent billing errors. We have argued strenuously to HCFA that when a carrier identifies that a physician has a billing problem, the carrier has an obligation to start a dialogue with the physician regarding the steps the physician can take to correct the problem.

The AMA has critical concerns about HCFA's post-payment audits. These audit procedures lack fundamental fairness. In order to avoid a total disruption of their practice, as well as expensive legal bills, physicians are frequently forced into civil settlements without the ability to appeal. In many cases auditors extrapolate hefty fines from a small sample of claims. At the hands of aggressive auditors, overpayments can quickly mount. We recommend that the Administration temper its rhetoric and refine its program initiatives so that those physicians honestly participating in the Medicare program are not subjected to the federal government's overly aggressive and punitive approach. The AMA urges the Administration and Congress to target their efforts toward ferreting out true fraud rather than penalizing honest physicians whose primary goal is to provide quality care to their patients.

Regulatory Relief

Physicians are voicing their growing concern about their Medicare and Medicaid patients access to quality health care services. Numerous unnecessary and unduly complicated administrative requirements interfere with the patient-physician relationship causing strain on both patients and physicians. These requirements increase the cost of care while reducing access for Medicare beneficiaries. If the Medicare program is to provide the nation's Medicare patients with greater access, greater choice and lower cost medical services, passage of regulatory relief legislation for physicians, hospitals, and other health care providers is a must. Examples include:

- *Physician input should be considered in annual carrier performance reviews.* In determining whether the Secretary of HHS will contract with a carrier to administer the Medicare program, the Secretary should consider physician input in evaluating whether to contract with that carrier.
- *Physicians should have an opportunity to provide substantive input before any "black box" commercial off-the-shelf software (COTS) is implemented by HCFA for code editing/bundling.* These "black box" methods do not draw on physicians' expertise and practical knowledge of the services billed. Their use distorts the billing process, discourages correct coding, creates inefficiencies and often results in physicians being paid less than the physician's cost of providing the service.
- *Carrier use of the extrapolation technique should be revised.* The practice of determining Medicare's estimated overpayment to a physician based on a statistical sampling of a small number of disallowable claims is inequitable. Carriers should identify a problem and provide the physician with an opportunity for a telephone discussion or a face-to-face meeting, in which the carrier must adequately explain how to correct the billing problem in the future. If a physician's future billing activities are found in error, HCFA may recoup overcharges based on actual errors found.
- *Carriers should be required to provide physicians, upon request and without charge, with carrier-generated information needed for the submission of claims.* This information includes the identifier number or other code of a referring physician, a list of maximum allowable charges, and coding protocols needed by physicians to submit a claim for payment or to respond to a carrier inquiry.
- *Carriers should compensate aggrieved individuals for violating Medicare policy.* Any individual, including a physician, who is aggrieved by the failure of a carrier to carry out Medicare policy, and establishes that the individual has suffered damages aggregating at least $500 as a result of the failure, should be permitted a hearing before the Secretary of HHS. If the carrier were found to have such failure, it should be required to compensate the aggrieved individual for such failure.
- *HCFA should develop and provide a Medicare compliance manual to all participating physicians without charge.*
- *Medicare should fund toll free lines used for the submission of electronic claims to the program.* Payment for use of a telephone line to submit electronic claims to Medicare is de facto a user fee. Medicare formerly provided this service at no charge.
- *Carrier medical review screens or associated parameters should be released before denial of physician claims.*

Conclusion

HCFA's ability to adequately manage the Medicare program is an issue of great importance to Medicare patients and the physicians who care for them. We implore the Committee to hold additional hearings to further assess the issues raised in our testimony, and encourage all Members of Congress to contact the AMA for further elaboration on issues addressed in our statement.

Statement of Christina Metzler, American Occupational Therapy Association, Inc., Bethesda, MD

The American Occupational Therapy Association (AOTA) submits this statement for the record of the hearing on February 11, 1999. AOTA calls your attention to an issue critical to the health, well being and quality of life of Medicare beneficiaries.

The change in the payment under Medicare for services in skilled nursing facilities (SNFs) from a cost-based system (with routine limits) to a fully prospective system (PPS) is causing tremendous upheaval in the occupational therapy profession. Practitioners are experiencing changes in their employment status, in their economic status, challenges to their professional standards and ethics, and, most importantly, limitations in their ability to provide adequate, appropriate, and required services to Medicare beneficiaries in these settings.

HCFA Oversight

AOTA is concerned that the Health Care Financing Administration (HCFA) is not adequately or effectively monitoring the implementation of this massive change. To our knowledge, HCFA has provided no guidance to fiscal intermediaries about medical review or quality assurance criteria to assure patients are receiving the care that nursing facilities are being paid for. We are not aware of any information transmitted to fiscal intermediaries on how to monitor the provision of care in relation to the payment received. Nor are we aware of any efforts by HCFA to empower the intermediaries with methods to determine the accuracy of the SNF categorization of individuals into appropriate RUG categories. AOTA urges that efforts be undertaken to assure nursing homes are not minimizing care, either intentionally or because of inadequate payment levels.

When Medicare payment to hospitals was changed to the prospective payment system in the 1980's, based on diagnosis-related groups (DRGs), hospitals used many ways to adjust to the new payment system. Not all were sensitive to patient needs and desired outcomes. In that post-DRG environment, many changes were observed and reported and beneficiaries felt the consequences. Increased use of outpatient pre-admission services billed to Part B, decreases in length of stay, and movement to non-hospital post-acute care settings were common. Also common were problems for patients and beneficiaries: transfer to nursing facilities unable to treat the acute conditions patients had, discharges to home with subsequent readmissions for exacerbations of conditions, and shifting provision of care to other, perhaps less appropriate, sites.

AOTA is concerned that similar negative consequences will accrue as the PPS is implemented by SNFs and that HCFA is neglecting critical oversight issues, which may jeopardize patient health and safety.

AOTA urges you to use your authority to hold HCFA accountable for instituting the proper guidelines and procedures to prevent problems that are likely to occur and to monitor changes in patient care and outcomes that may result from the change in the payment system. Patients in skilled nursing facilities are too vulnerable to be left to suffer the vagaries of funding changes without some protection from the agency charged with that duty.

General Accounting Office Testimony

AOTA is concerned about issues raised in the testimony of the General Accounting Office (GAO). First, we would like to support GAO's statement that "the SNF PPS has design flaws" and that this is "coupled with a lack of adequate planned oversight" by HCFA. While GAO merely raises the specter of less than expected savings from the combination of these two problems, AOTA is deeply concerned for patient welfare under a system that is "flawed" and, as GAO admits, the implementation of which is unfettered by appropriate oversight.

GAO goes on to state that "the new SNF PPS' design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services, since the amounts paid still depend heavily on the number of therapy and other services patients receive." This statement has no connection to the reality our therapists and their patients are experiencing in SNFs and belies the experience and common sense understanding of capitated payment systems. GAO appears not to understand the other major problems with the PPS system: the incentives to under provide, under identify, and provide minimal care for patients.

For instance, rules for using qualified professionals to provide therapy services are being skirted. Standards of supervision of aides and assistants, though covered by law in most states and reaffirmed in Medicare regulation, are a particular area of concern. If standards of care, including use of qualified personnel, are not upheld, patients will suffer loss of function and reduced health status and the purposes of the Medicare program will not be achieved.

Indeed, if standards of care are not reaffirmed by HCFA direction and assured by HCFA oversight, patients' health care needs will increase, thus further limiting savings by increased hospitalization and other service utilization.

AOTA urges the Committee to hold hearings on SNF quality and the PPS system. AOTA also supports the notion raised by Chairman Thomas during the hearing that perhaps a "town hall" meeting with HCFA, Congress, MedPAC, GAO and affected members of the public, including health professionals, would be useful to discuss problems with the RUGs system.

Specific Requests

In addition we urge the Committee to question HCFA further on its lax oversight.

Specifically:

When will HCFA issue medical review guidelines for fiscal intermediaries to assess correct and appropriate categorization of patients?

When will HCFA put in place quality assurance mechanisms to assess any decreases in patient access to care and subsequent deterioration in patient status due to the move to PPS?

When will HCFA institute guidelines and procedures to assure that nursing homes are not minimizing care, either intentionally or because of inadequate payment levels under PPS?

What plans and timetable does HCFA have to develop the medical review process required in the Balanced Budget Act, now Sec. 1888 (d)(1) of the Social Security Act?

What immediate steps will HCFA undertake to assure quality services are adequately and appropriately provided with no negative impact on patients until such medical review criteria and processes are established?

What steps will HCFA take to assure that patients, once classified into a Resource Utilization Group (RUG) will receive services appropriate to each individual's condition and not simply the minimum for classification into a category?

What steps will HCFA take to monitor access to the appropriate clinical professionals to meet the full spectrum of patient needs as assessed by the Minimum Data Set process?

Legislative changes

In addition, AOTA believes the Committee must look at legislative changes that will improve the functioning of the system, and prevent some potential abuses of payment and patient care.

AOTA urges the Committee to consider a legislative change to allow facilities to move immediately to the full federal rate. The three-year transition period was intended to allow for a gradual absorption of the process changes and the funding reductions. However, when the rates for many facilities for some RUGs categories are reviewed, there can be a significant difference between the full federal rate and the combined, transitional rate. For instance, for one facility whose rates we have reviewed, the first year transitional rate for the ultra high rehabilitation category is $294.59 per day while the full federal rate is $409.29, for a difference of more than $110 per day. HCFA developed the federal RUGs rates based on resource requirements to meet the service needs identified for these categories. Yet the discrepancy is so significant, we question whether a facility would even choose to place a patient in this category, denying them access to needed therapeutic interventions and other services. Several categories of a lesser intensity have full federal rates and transitional rates that are more closely aligned providing an incentive to downgrade patients, providing fewer services. The Committee should request a report from HCFA on these discrepancies and identify which categories and facilities are more vulnerable to underpayment. AOTA urges Congress to allow facilities that identify such a discrepancy to request use of the full federal rate immediately. With proper HCFA oversight, this could serve to prevent three years of operation on terribly inadequate funding levels, with severe consequences for patients.

Another issue in the RUGs categories is the lack of requirements for more than one type of therapy to be provided to patients who are in high and very high rehabilitation categories. Under the demonstration project which developed the RUGs, we understand that patients in the high and very high categories were required to receive more than one type of therapy. The rationale was that if a patient had needs complex and involved enough to require a significant number of minutes of therapy per week, then that patient logically needed more than one type of intervention. We also note that in the demonstration project these categories required a lower number of minutes; now the ultra high category is the only one requiring the use of more than one type of therapy. It was established for the PPS implementation. AOTA questions HCFA's change in this policy, especially as the high and very high categories may include more complex patients than in the demonstration. We urge the Committee to clarify and correct the requirements in the high and very high categories.

AOTA also believes legislation should be considered to allow for a pass-through or exception process for high cost items such as durable medical equipment and orthotics/prosthetics/supplies These items, according to anecdotal reports from our members, are not always being provided as part of a patient's treatment protocol under Part A. It is believed that patients may be forced to wait until Part B can be billed separately to provide such items as prosthetic legs. Proper fitting as well as training by therapists in the use and care of the prosthesis are required before the patient leaves the SNF, especially for safety of the patient when s/he returns home and to community life.

The Committee should conduct an inquiry on this issue and consider legislation to allow these items and services, the costs of which are controlled by existing Medicare limits, to be billed separately to assure needed equipment and services are provided in a timely and appropriate manner. Patients should not have to wait until the end of their SNF stay to obtain a proper, well-fitting and functional prosthetic leg or arm. Yet the current payment amounts appear inadequate for facilities to be compelled to provide them as soon as possible.

In addition, AOTA urges the Committee to investigate how an outlier system might be developed to assure that patients that do not fit into even the highest reimbursement categories are not deprived of necessary services.

Maintain Intent of OBRA; Conduct Studies

The protection of the health and quality of life of nursing home patients has been frequently addressed by Congress. Congressional intent and expectations are clearly stated in the protections included in the 1987 Omnibus Budget Reconciliation Act which assure the public interest in patients maintaining highest possible function, being free of inappropriate restraints, and achieving optimum physical and mental health. AOTA believes that it is Congress' duty to assure that the changes it made in the Balanced Budget Act are not implemented in a way that is contrary to the important safeguards established in OBRA.

Because our members are being laid off, are spending less time with patients because of cutbacks in hours, and are being asked to adhere only minimally to standards of appropriate practice, AOTA is concerned that there will be increases in health and other problems in nursing facilities. We believe the Committee should ask GAO to act on its concerns about SNFs under PPS and immediately undertake a monitoring effort to look at questions such as the following:

Comparing charts of similar patients one or two years ago with post-PPS charts, are there changes in patient routines? (E.g., are patients in bed more and moving to activities less?)

Is use of pharmaceutical or other restraints increasing because reduced hours of receiving therapy are causing cognitive or behavioral problems?

Is there an increase in problems such as decubiti ulcers (bed sores), incontinence, pneumonia, and circulatory problems which can be linked to fewer hours spent receiving therapy, and loss of function and slower recovery due to receipt of less therapy?

Are there more feeding and hydration problems because occupational therapy or speech-language pathology services are not provided to address feeding or swallowing problems?

Is nursing staff following different routines with patients because of increased burdens of care due to less access to therapy?

AOTA is aware that there are concerns about some therapy services provided to SNF patients in the past. Even if some therapy was improperly documented or not appropriately authorized, the reductions in the amount of therapy patients are and will be receiving based on the staff and contract cuts observed in the SNF sector are, in our view, disproportionate to reductions in payment and to any amount of possible overutilization. AOTA is very concerned for patient well being and protection under Medicare standards and the OBRA requirements.

AOTA urges the Committee to move forward with dispatch on its agenda to hold hearings on the implementation of the PPS and on quality issues. AOTA urges the Committee to pursue efforts to gather better data on the status of patients and the care they are receiving. AOTA urges the Committee to address the needed administrative and legislative changes that can improve the PPS system, enabling it to achieve cost savings without sacrificing patient health, safety and well-being.

Statement of Mark Knight, Association for Ambulatory Behavioral Healthcare, Alexandria, VA; Al Guida, National Mental Health Association, Alexandria, VA; and Pope Simmons, National Council for Community Behavioral Healthcare, Rockville, MD

To: A.L. Singleton, Chief of Staff

From: Mark Knight, Executive Director, Association for Ambulatory Behavioral Healthcare; Al Guida, Vice President, Government Affairs, National Mental

Health Association; Pope Simmons, Vice President, Government Relations, National Council for Community Behavioral Healthcare

Re: Management of the Medicare Program Hearing on February 11, 1999 at 2:30 pm

Date: February 24, 1999

Thank you for the opportunity to share our perspective on the current problems impacting on the Medicare Partial Hospitalization Program and to suggest ideas on legislative and administrative solutions.

The findings in the October 1998 Office of the Inspector General report, Five State Review of Partial Hospitalization Programs at Community Mental Health Centers," address two separate issues, which understood together, are very troubling indeed. The first issue has to do with the definition(s) of Community Mental Health Centers as a venue for providing Partial Hospitalization Services, and the second, with concerns related to medical review of partial hospitalization claims. We will discuss each of these issues in turn and then explain how taken together, they have contributed to the serious problems identified in the OIG report. Finally, we will make some suggestions on legislative and administrative solutions.

1. Federal definition and State-by-State implementation of Community Mental Health Centers has been unclear and inconsistently interpreted from their inception, more than 30 years ago.

In 1990, when Section 1861 (ff) of the Social Security Act was amended to permit community mental health centers to provide Medicare covered partial hospitalization services, there was a recognition that many Medicare recipients were individuals with serious and persistent mental illnesses who were being treated in community systems of care; and further that a level of care between inpatient and outpatient service would benefit the recipient and avoid costly and unnecessary inpatient hospitalization.

However, the law was vague and created a loophole. It defined a community mental health center as an entity which (1) provides services described in section 1916© 4 of the Public Health Service Act[1], and (2) meets applicable licensure or certification requirements for community mental health centers in the State in which it is located. In order to receive a Medicare provider number under current law, a CMHC simply has to sign an attestation agreement that it meets these two requirements. Since the operational meaning of the Public Health Service definition has never been clearly defined (and has been differentially interpreted across time and place)—and nearly two/thirds of the states have no distinct CMHC licensure requirements, some individuals and newly created organizations took advantage of this loophole and got into this program for the wrong reasons.

2. The original authorizing language (Section 1861 (ff) of the Social Security Act) defining partial hospitalization and the physician certification requirement in Section 1835(a)(2)(F) has created contradictory language resulting in confusion as to the type of patient who is appropriate for partial hospitalization and the kinds of services that would be considered covered services under the Medicare program.

In Section 1861 (ff), partial hospitalization is defined "as those services which are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization."

In Section 1835(a)(2)(F), it states that as a condition for reimbursement, a physician must certify that "the individual would require inpatient psychiatric care in the absence of partial hospitalization services."

According to the former, if the service simply prevented relapse and maintained the patient's level of functioning, such services would fall under the definition. In contrast, the physician certification requirement is explicit that the patient must be in an acute situation (i.e., in imminent need of hospitalization).

3. Taken together, these contradictions and vagaries of the law have made the Medicare PH program a very difficult program for HCFA to implement and for its contractors to adjudicate.

When combined, the lack of clarity in the law, inconsistencies in interpretation, and wide variance in implementation of both Community Mental Health Center

[1] These services include: (1) outpatient services to children, the elderly, and the serious and persistent mentally ill, (2) day treatment, psychiatric rehabilitation, or partial hospitalization services, (3) 24 hours a day emergency care, and (4) screening for patients being considered for admission to a mental health facility.

definitions and Partial Hospitalization Programs, create a double-edged sword for Community Mental Health Centers attempting to provide a legitimate, authorized venue and appropriate covered services to beneficiaries for whom partial hospitalization is medically necessary. Likewise, the absence of clear and consistent interpretation invites fraud and abuse in both CMHC and Hospital-based Partial Hospitalization Programs.

4. How has this played out in the implementation and adjudication of this program?

There have been recent efforts to clarify both the Medicare definition of Community Mental Health Centers as a venue for the purpose of providing Partial Hospitalization Services, and the definition of the Partial Hospitalization Program itself. Both efforts have been wrought with significant challenges.

(A) Efforts to clarify the definition of a CMHC.—Current efforts have underscored the conflicting current definitions of the Community Mental Health Center core services. Earlier this year, HCFA central office and its Southern Consortium (Regions 4 and 6) implemented a project to verify that CMHCs were providing the four core services to which they attested in their original agreement. Beginning in January 1998 and ending on August 30, site visits were conducted at all current Medicare CMHCs and selected applicants in Florida, Texas, Georgia, Mississippi, Arkansas, Alabama, South Carolina, Tennessee, and Louisiana. This initiative was problematic because what was being verified was not clearly defined in measurable, operational terms, and in some cases, those conducting on-site visits had no psychiatric training.

Where this problem is most dramatic is in the interpretation of the core service defined as "screening for patients being considered for admission to a state mental health facility." HCFA is interpreting this requirement to mean that the entity conducting the screening must also have the authority to admit the patient to a state mental health facility. While all CMHCs had the authority to admit patients to state mental health facilities following enactment of the Community Mental Health Center Act of 1963, since that time, the system has changed considerably. Currently, some CMHCs have a contract to do this and others do not, and some are simply not able to get such a contract because they are not considered part of the public system. Further, in some states, there is not a state mental health facility to which patients can be admitted. Finally, in some states, only the state mental health facility has the authority to admit a patient.

(B) Efforts to clarify who is appropriate for Medicare PHP and which services are covered.—Medical review policy is at the discretion of individual fiscal intermediaries. HCFA's 1995 National Memorandum on Partial Hospitalization and the 1997 Model Local Medical Review policy have helped to clarify certain guidelines for medical review overall, but these are inconsistently interpreted and regarded by fiscal intermediaries at a local level. What constitutes a provider's compliance and results in payment under one fiscal intermediary, could easily fail to comply and result in denial of payment under a different fiscal intermediary. Increasing scrutiny of Partial Hospitalization will not be a useful tool unless we clarify, understand and achieve greater consistency of the fiscal intermediary local medical review policies against which programs are scrutinized. Therefore, aggregation of Partial Hospitalization denial rates across fiscal intermediaries is not a valid measure at present.

5. Recommendations.

1. The law should be amended to clarify the definition of a CMHC and of partial hospitalization. In regard to the former, the four core service definition should be amended so that it accurately reflects how community mental health centers currently operate (See National Council for Community Behavioral Healthcare).

In regard to the later, challenges with the Medicare partial hospitalization program present an opportunity to reconsider Medicare coverage of the continuum of mental healthcare. Because of gaps in coverage, in some cases, patients may be admitted to PH when they would benefit from a less intensive level of care. Thought should be given to building upon the demonstration program in H.R. 2640 which would permit CMHCs to provide a more flexible array of mental health services. In a similar vein, the 120 day intensive nonresidential treatment services benefit that was proposed in 1994 as part of the Democratic healthcare reform legislation should be dusted off!

2. A formal rulemaking process should be initiated as soon as possible to develop clear and measurable certification standards with industry, clinician and patient input. HCFA should expedite a regulatory process for promulgating clear conditions of participation. This approach is consistent with that taken with other Medicare benefits.

GREEN CROSS, INC.
MIAMI, FLORIDA
February 24, 1999

A.L. Singleton, Chief of Staff,
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Re: Oversight of HCFA's Management of Medicare: For inclusion in the printed record for the hearing of Feb. 11, 1999.

To Whom It May Concern:

HCFA has grossly mismanaged the Medicare Program as it relates to Mental Health Care. In the State of Florida HCFA failed to publish conditions of participation for Community Mental Health Centers. When this area blew up with several hundred centers, then HCFA proceeded to use Draconian methods to crack down and close programs without gauging the damage that this would do to patient care. Hence, we have a problem created by HCFA's poor management, giving out provider numbers freely to anyone who applies, then using a reckless approach to kill the industry.

Mental Health Care in Florida has been underserved and underfunded for years. The Federal Government agreed to allow Mental Health Centers to provide Partial Hospitalization Services and have it reimbursed by Medicare. In Florida, there were no guidelines or licensure protocols for Community Mental Health Centers, and HCFA provided none. So, by 1997 there were more programs in Florida than in any other state. Almost anyone could apply and receive a provider number for this service. Again, this could have been averted if HCFA would have issued guidelines or conditions for participation like they do in almost all other areas of health care.

To further compound this problem Partial Hospital Benefits was placed under cost reimbursement. That is, programs are reimbursed on cost. The higher the cost, the greater your reimbursement. This again encouraged ever escalating cost on top of the ever escalating number of providers.

By the end of 1997 it was clear that the industry had gotten out of hand. There were providers in every street corner and costs were growing exponentially. HCFA then decided to crack down using a three-pronged approach: (1) Medical Review instructing the fiscal intermediary to implement a Medical Review of charts placing programs on a 100% and denying all charts based on not meeting admission criteria. (2) Provider Audit and Reimbursement Department (PARD) (3) Criteria for Community Mental Health Centers inquires of service.

On the issue of Medical Review, Blue Cross and Blue Shield of Florida took a stance of denying almost all charts reviewed placing programs on 100% review, thereby shutting off all funding to the program. When confronted with these facts, Curtis Lord, President of First Coast Services made a statement "There was a point by last March or April where we kicked a lot of people up to 100% without regard to all this. We made a concerted effort to bump the majority of providers up to 100% until we could get a handle on what was going on, and I don't think we did that by considering all individual cases. I think it was a pretty large movement of the community to a 100% review" (exhibit A) at a meeting with representatives of the Florida Association of Community Mental Health Centers (FACMHC). A local contingent of Congressmen and women became involved and a letter was sent to Secretary Donna Shalala (exhibit B). After having a meeting in Atlanta in which Ms. Rose Crum-Johnson of HCFA's Atlanta Office agreed to accept a sampling of charts that had been denied by Blue Cross & Blue Shield, and to send them to an independent psychiatrist that HCFA would contract. As can be seen in the results reported to us by HCFA (exhibit C) "sixteen of the eighteen patient for whom charts were submitted were eligible to receive PHP." This re-confirms the grossly inappropriate and unfounded decision to place programs on 100% medical review and deny all claims for the same issues—especially when those reviewing the claims were far less qualified than a psychiatrist. This pattern of poor management is further compounded by the action of the Provider Audit and Reimbursement Dept. (PARD).

PARD typically takes two years to complete a desk review of a cost report, at which time they are able to deny listed expenses as non reimbursable. In many cases, these decisions are taken in an arbitrary manner. If an expense was incurred two years ago and hence continued in a program's budget through the present day then their adjustment will reverberate across three years into the current year.

Hence, an adjustment to one year when multiplied by three can result in a devastating impact to a program. PARD does not issue clear guidelines on what it feels are reasonable costs and salaries. PARD never requests a proposed budget for the future for review which would aid in planning and management. Instead, their adjustments are retrospective when money has already been spent on patient care. If a cost report shows an amount payable back to the Medicare Program they want the money immediately. If it shows a receivable to the program then they hold on to the funds until they complete their desk review two years down the line. The issue of compensation for bad debts is also an area of great concern as far as PARD. In Florida, the Medicaid Program, which at the Federal level is administered by HCFA, refused to grant crossover provider numbers to many PHP programs early on. Hence, programs serving the poor were unable to collect the 20% co-payment and deductible from Medicaid. In filing cost reports, these are very real bad debts. However, it has been the policy to deny these bad debts as reimbursable costs because Medicaid should have covered it. Hence, programs are left in the untenable position of subsidizing the State's Medicaid Program. An example of this can be seen in (exhibit D), a letter from Steel Hector & David, LLP to the State of Florida's Attorney, Gordon Scott. Many of these issues still remain in contention without final resolution. If resolved unfavorably it can be devastating and shut down any program finding itself in this quandary.

The third prong of this assault comes from the "Core Areas of Service" to qualify as a "Community Mental Health Center." HCFA has never issued conditions of participation and has never been clear as to what constitutes compliance. In the last 18 months HCFA has been ever more nebulous and at the same time aggressive in trying to "decertify" programs for not fulfilling the four core areas of service. Almost all programs have some compliance plan in place. However, since HCFA constantly changes its articulation of criteria they leave open the possibilities of "pulling out the rug" from under a program claiming it doesn't meet their latest, arbitrary and hazy interpretations (see attached exhibit E).

A summary of how many of these issues can affect a program can be seen in the letter sent to Mr. Michael Hash, Deputy Administrator of HCFA, in reference to Green Cross, Inc., a Joint Commission accredited facility in South Florida (exhibit F). In conclusion, in the area of outpatient mental health services, HCFA has demonstrated extremely poor management of the Medicare Program. Without question, patients have been very much affected and have expressed great concern (exhibit G is a letter of concern from patients). Action needs to be taken so that HCFA and its contractors act in a professional manner and work with providers to care for the nation's sick and needy rather than persisting in an adversarial relationship. Whenever there is "fraud and abuse," I suggest the main culprit is weak and poor management on the part of HCFA.

Should you have any further questions or require any more information, please do not hesitate in contacting me.

MIGUEL A. NUÑEZ JR., M.D.

[Attachments are being retained in the Committee files.]

Statement of the Health Insurance Association of America

The Health Insurance Association of America ("HIAA") is pleased to present this written testimony to be added to the records of your hearing of February 11, 1999 on the "Management of the Medicare Program." As the preeminent health insurance trade association, HIAA is the principal voice of the broadest spectrum of the health insurance industry. HIAA represents over 265 members that include commercial insurers, health maintenance, preferred provider and managed care organizations and businesses that provide products and services to the health insurance industry. Together, HIAA members provide health, long-term care, supplemental, and disability income insurance coverage to more than 110 million Americans. Association members include companies currently serving as Medicare+Choice managed care contractors, companies who are considering offering new Medicare+Choice options, and companies that have recently withdrawn from the Medicare+Choice program, giving us a unique perspective on the issues under review by this Committee.

I am pleased to have this opportunity to discuss the implementation of the Medicare+Choice program with you and to share a few of our principle concerns. We believe that the Medicare+Choice program represents an essential component in the government's effort to ensure the financial survival of the Medicare program and to meet the health care needs of the baby boom generation as we move into the 21st

Century. HIAA applauds the Commerce Committee for its role in shaping these bold Medicare reforms through the Balanced Budget Act of 1997. Recent developments, however, suggest that the Committee's work is not yet done. To ensure the promise of the reform, and to facilitate beneficiary choice under the Medicare program, additional legislative and policy modifications must be made.

CONCERNS ABOUT LOW ANTICIPATED MEDICARE+CHOICE ORGANIZATION PAYMENT RATE INCREASES

1. Limits on Annual Increases in Capitation Rates and Concerns Regarding the New Proposed Risk Adjustment Methodology Threaten the Continued Attractiveness of the Medicare+Choice Program to Beneficiaries and Providers

a. Most Plans Will Experience Cost Increases From Medical Inflation That Exceed Payment Increases During the Coming Year.—Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's payment methodology enacted by the BBA. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of providing health care and permit necessary investment in clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, clinical and operational objectives.

As set forth in Section 1853(c) of the BBA, Medicare+Choice organizations will be paid the greater of:

(a) a blended capitation rate, which is the sum of a percentage of the area-specific capitation rate and a percentage of the national Medicare+Choice capitation rate (the percentage balance will change over time until it reaches a 50/50 blend in 2002); or

(b) a minimum amount, which is $379.84 per enrollee per month in 1999; or

(c) a minimum percentage increase for 1998 equal to an increase of 2 percent of the 1997 Adjusted Average Per Capita Cost ("AAPCC") rate for the particular county, with increases of 2 percent in each subsequent year.

Due to a budget neutrality requirement, the blended capitation rate was not available in 1998 or 1999. The Health Care Financing Administration (HCFA) anticipates, however, that the blend will apply for the first time in the year 2000. While the majority of counties will receive blended payments, it is HIAA's understanding that approximately 30 percent of counties will continue to receive the floor amount and 11 percent of counties will receive the minimum two percent increase.

The practical result, based on actual Medicare+Choice enrollment, is that Medicare+Choice organizations serving a majority of Medicare beneficiaries enrolled in such organizations will receive rate increases of the minimum 2 percent or only slightly more. For many—if not all—of these organizations, this increase would not be sufficient to cover the increased cost of providing mandated services, given projected medical inflation [1]. This, combined with the fact that many Medicare+Choice organizations experienced significant losses in 1998 (and anticipate additional losses in 1999), forecasts trouble for the program.

Indeed, inadequate reimbursement rates largely were responsible for the retrenchment of Medicare+Choice plans last Fall. At that time, some of the most respected Medicare+Choice organizations in the country withdrew from states and counties with low capitation rates. Other withdrawals occurred in low enrollment areas even though capitation rates were above average. As reported, 42 health plans decided to withdraw from the Medicare+Choice program and 53 plans decided to cut back their services. In all, about 400,000 Medicare beneficiaries were effected. To put this in perspective, HCFA averaged two Medicare risk contract cancellations per year from 1993 through 1997.

The use of the blended rate for some Medicare+Choice plans for the first time in 2000 is clearly a step in the right direction in terms of ensuring fair and adequate reimbursement. However, HIAA strongly believes that additional adjustments are necessary to attract and maintain the number and diversity of Medicare+Choice organizations necessary to establish a sound and attractive market-based alternative to the traditional fee-for-service program.

---

[1] The budget for fiscal year 2000 includes funding original fee-for-service Medicare that reflects anticipated increases in medical costs over a five year period of 27% and an increase in the Federal Employee Health Benefit Program of about 50%. Estimates of the likely growth for Medicare+Choice plans in high paying counties for the same period is less than 10%.

Accordingly, HIAA urges Congress to reconsider the artificial and arbitrary limits on capitation rate increases set forth in the BBA. Specifically, HIAA suggests that annual increases in Medicare+Choice payment rates be sufficient to fully cover medical inflation experienced in the local markets. Because local employer health plans and other commercial customers have a tremendous incentive to keep costs down, they will positively affect the inflation rate in each market. If the current reimbursement structure is not adjusted, more Medicare+Choice organizations are likely to withdraw from areas served and beneficiaries enrolled in the remaining plans will likely experience premium increases or reduced benefits. Finally, as Medicare+Choice plans leave the market, the original Medicare program (with its higher per capita costs) will have more beneficiaries and put additional strain on both the Part A Trust Fund and the budget.

b. The New Risk Adjustment Methodology Will Substantially Reduce Payments to Medicare+Choice Organizations.—Change in the Medicare+Choice payment calculations is all the more necessary because the risk adjustment process which HCFA is implementing is expected to substantially reduce aggregate payments to Medicare+Choice plans while adding additional administrative requirements and expenses. According to preliminary HCFA estimates, total Medicare+Choice plan revenues for the year 2000 are projected to be $200 million less than they would have been under the Adjusted Average Per Capita Cost ("AAPCC") payment method and $6.3 billion less in 2004. As a result, some plans will see even their minimum two percent increase eroded in 2000 as the risk adjustment methodology is phased in. Thus, what began as a straightforward effort to more accurately compensate plans for the health care costs of their particular members will, unexpectedly, result in an overall reduction in funds to Medicare+Choice organizations.

This development runs counter to HIAA's understanding of Congressional intent, i.e., that the savings resulting from the percentage reduction[2] in plan payments for years 1998 through 2002 was intended to be in lieu of any net program savings from risk adjustment. (Indeed, the Congressional Budget Office did not score any projected savings in connection with the risk adjustment program under BBA 97). The new methodology, and huge projected revenue reductions, underscores HIAA's concerns regarding the inadequacy of plan payments under Medicare+Choice. To the extent that the proposed HCFA risk adjustment methodology translates into a significant overall decrease in payments for the Medicare+Choice program, it will undoubtedly be an additional deterrent to program participation. Accordingly, HIAA urges Congress to require HCFA to modify the risk adjustment methodology so that aggregate payments to Medicare+Choice plans for 2000 and beyond are based on aggregate BBA adjustments, making the risk adjustment process budget neutral.

c. The User-Fee "Tax" on Medicare+Choice Organizations for Beneficiary Education is Inequitable and Reduces Even Further Payments to Medicare+Choice Organizations.—HIAA strongly supports educating and informing Medicare beneficiaries about all coverage options, including the Medicare+Choice program, and supplying beneficiaries with straightforward, unbiased information to help them choose appropriate coverage. That said, we are concerned that the BBA, to support beneficiary education activities for all 37 million beneficiaries, places a "user fee tax" on Medicare+Choice organizations only.[3] The educational campaign is a benefit to all Medicare beneficiaries. Indeed, initial information suggests that the toll-free number HCFA established last year with funds from the $95 million dollar "tax" assessed upon Medicare+Choice organizations primarily fielded calls from beneficiaries seeking information about the fee-for-service program. Considerations of equity dictate that the educational program—which informs beneficiaries about basic program benefits and requirements—be funded from the Medicare trust fund, or another broad-based source of revenue, as are other such essential program functions.

We note that this tax, which is .355% of the total monthly payments to each Medicare+Choice plan in 1999, further exacerbates the problems outlined above concerning inadequate reimbursement. Indeed, when the user fee tax is combined with potential large revenue reductions from risk adjustment, some existing Medicare+Choice plans will see little or no increase in their payment rates from

[2] In addition to the 5 percent reduction in payment from fee-for-service costs which existed prior to the BBA, the increase in payment to Medicare+Choice organizations under both the blended rate and the floor will not fully reflect anticipated medical inflation. A reduction of 0.8 percent was made in 1998 and reductions of 0.5 percent are to be included in 1999 through 2002. The cumulative effect of these reductions will be that even the blended rate adjustment will be inadequate. This, coupled with the insufficient increases in the minimum rate, will undermine Congressional intent to encourage growth of Medicare+Choice options for seniors in low cost areas.

[3] Medicare+Choice organizations essentially pay a "head tax" (i.e., an amount based on the number of Medicare+Choice enrollees in their plan) to support the public information program.

1999 to 2000 even though HCFA is using a phase-in of an interim risk-adjustment methodology.

The cumulative effect of these three payment reductions will vary depending upon the relationship of the current payment, current benefits, and the number of beneficiaries enrolled.

In your district, Chairman Thomas, there were 33,527 beneficiaries enrolled in Medicare risk plans (or 29.1% percent of Medicare beneficiaries). We project[4] that Medicare+Choice plans will receive only 53.3% percent of the increase per capita relative to Medicare fee-for-service increases. We also project an increase in the 65+ population from 103,296 in 1998 to 117,030 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by $14.6 million[5] from your district alone.

In your district, Representative Stark, there were 137,276 beneficiaries enrolled in Medicare risk plans (or 41.9% percent of Medicare beneficiaries). We project that Medicare+Choice plans will receive only 46.2% percent of the increase per capita relative to Medicare fee-for-service increases. We also project an increase in the 65+ population from 312,704 in 1998 to 351,438 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by $72.8 million from your district alone.

Overall, the average increase per capita to Medicare+Choice plans will be 49.5% of the expected increase in the period 1997 to 2003 per capita to the fee-for-service portion of Medicare. In some areas of the country, Medicare+Choice plans may get less than $50 more per month over this entire period to deal with medical inflation.

2. The May 1 Deadline for Filing ACRs Has Created Serious Problems in the Administration of the Medicare+Choice Program and Should Be Changed to November 1

The BBA moved the deadline by which Medicare+Choice plans must submit their adjusted community rate (ACR) proposals from November 1 to May 1. This was done in order to allow HCFA sufficient time to approve rates and include this rate information in the materials to be distributed to beneficiaries as part of the educational campaign. The problem with this time frame is two-fold. First, by submitting proposals seven months in advance of the actual effective date (i.e., January 1), plans place themselves at substantial risk that health care costs will rise in unexpected ways in the latter half of the year and thus not be captured in the proposals. This is what occurred last year, contributing to the decision by many Medicare+Choice organizations to not renew their Medicare+Choice contracts for 1999, or to reduce their service areas. Also, proposals submitted by May 1st are based on relatively limited claims experience with the Medicare beneficiary population enrolled in the more rapidly growing plans and are thus less likely to be accurate predictors of costs than proposals based on a longer period of time. Accordingly, HIAA proposes moving the ACR deadline to November 1 or as close to that date as operationally possible.[6]

In regulations published earlier this month, HCFA "recognize[d] the difficulties inherent to estimating the cost of a benefit package for 2000 based on at most 4 months of experience under the 1999 benefit package," but indicated that it had no discretion in this matter due to the statutory mandate. The President's fiscal year 2000 budget includes a proposal that would extend the deadline for ACR submissions until July 1. HCFA strongly supports this proposal. Given the importance of this issue to Medicare+Choice organizations, and the concerns involved HIAA urges the Committee to take steps to put in place a permanent workable deadline for ACR submissions and suggests that an ACR date of November 1.

3. Congress Should Return to the Previous Policy Allowing Flexible Benefits and Premiums Within a Service Area

---

[4] Our projections of the change from 1997 to 2003 utilize September 1998 enrollment figures, a 1998 Price Waterhouse report on Medicare Capitated Payments, and reflect HCFA's assumption for the average cost to Medicare+Choice organizations of risk adjustment.

[5] Lost savings, based on the difference in projected per capita payments to HCFA *vs.* Medicare+Choice, multiplied by the potential Medicare+Choice enrollment less 75 percent of current enrollment.

[6] We recognize that HCFA may prefer a date earlier than November 1 in order to collect information for the annual public information campaign. We believe that HCFA's public information objectives can be met while permitting Medicare+Choice organizations to submit ACRs on the old schedule. Working with third party publishers, including daily newspapers, HCFA could more than adequately distribute plan specific information to beneficiaries in a timely fashion.

Historically, Medicare risk contractors were able to offer different benefit or charge structures within a given contracted service area. For example, modified benefit packages were often developed and offered in a subset of the contracted service area. While Medicare beneficiaries residing in the segmented service area were offered a uniform array of benefits at a uniform price, uniformity was not required across the entire service area. This flexibility was important because it allowed contractors to adjust their benefit package and premium structure to take into account differences in capitated payment rates received, which varied by county.

In the BBA, Congress mandated a new policy requiring that organizations offer uniform benefits and premiums throughout a service area, despite varying payment levels. Under the Medicare+Choice regulations, an organization may offer multiple plans and propose different services areas for each plan. (Were this not the case, organizations would be discouraged from expanding to outlying rural counties that typically offer lower reimbursement rates.) This regulatory policy allows Medicare+Choice organizations to achieve results similar to the original flexible benefit policy, but only at significant additional expense. Instead of one ACR being filed for a broad service area with benefits modified to reflect anticipated revenues, as used to be the case, multiple ACRs must be generated for separate Medicare+Choice plans by each organization, and reviewed and approved by HCFA. The Congressional mandate thus imposes significant administrative costs on the organizations and the agency, with absolutely no benefit to beneficiaries. Therefore, HIAA urges Congress to repeal the uniform benefits and premium provisions of the BBA.

In Many Places the Regulations are Overly Rigid and Demanding so They Become an Impediment to Small and/or Rural Medicare+Choice Organizations

1. The Quality Assurance Approach is Misguided

HIAA believes that some form of quality standards are important to any market-based approach to Medicare. Without quality standards, or some other performance measurement, the added costs of maintaining quality will be difficult to present fairly although over time, it will be obvious. That being said, HIAA has serious concerns about the breadth and depth of the onerous quality assessment, performance improvement and performance measurement standards developed by HCFA.

a. Performance Measures Should Vary More by Type of Plan.—As an initial matter, we believe that performance measures should be designed to fit the services offered by various types of plans. HCFA, however, has essentially embraced a "one size fits all" approach. As a result, it is unlikely that Medicare+Choice PPO plans that offer a broad choice of providers to beneficiaries (but are loosely "managed") will be able to meet the quality requirements. Similarly, the extensive quality-related requirements applied to MSA plans and private fee-for-service plans are likely to deter the necessary investment required before these types of plans can be offered. The bottom line is that the HCFA regulations are so inflexible that few options other than existing managed care arrangements with large numbers of beneficiaries can be developed. As a result, beneficiary choice will suffer, and a key goal of the Congress' work on BBA will have been defeated. In rural areas with no existing private health plan options, these regulations effectively preclude any chance that new choices will develop under most reasonable financial scenarios.

b. The Extensive Data Collection Proposed Is Not Necessary.—Second, the extensive data collection and reporting efforts required under the regulations will add significant administrative costs to Medicare+Choice organization operations. We question whether these costs are justified or desirable, and whether the quality assurance goals might not be met just as well through alternative approaches. HIAA strongly believes that consumers, not government officials, should dictate through their plan choices the extent and nature of quality improvement, balanced against costs. Under this approach, organizations that are responsive to consumer preferences would be rewarded with greater market share. Fewer government resources would be required for oversight.

HCFA could, however, play a central role in ensuring that minimum standards are met and encouraging quality initiatives through flexible, incentive-based standards established by contracts. HCFA is to be congratulated for posting beneficiary satisfaction survey results and other such information on the Medicare internet site (www.medicare.gov). In HIAA's view, this would be far superior to the current practice of setting detailed regulatory mandates which run the risk of leading to micromanaging and encouraging uniformity at the price of creative experimentation.

In trying to determine the cost of the extensive data collection effort proposed, HIAA notes that many health care organizations, particularly those with loosely managed network-style delivery systems (such as PPOs) do not currently have the capability to capture or report performance data at the level being proposed. The BBA's limitations on increases in capitation rates means that outside sources will be required to fund system upgrades. Even if financially possible, the time required for procurement, installation, training, and validation are not consistent with HCFA's scheduled implementation and reporting requirements for Medicare+Choice plans. As a result, these quality assessment requirements will be a significant deterrent to expanding senior's choices as potential new plans decide not to participate in the Medicare+Choice program. At the very least, HIAA believes that organizations making a good faith effort to meet the regulatory requirements should be provided a transition period where penalties would not be imposed. This is particularly important given plan efforts to address Year 2000 computer issues.

c. The "Deemed Status" Program Should Be Implemented Immediately.—Most Medicare+Choice organizations already adhere to rigorous quality assurance review by nationally accredited health care organizations. HCFA has provided by regulation that Medicare+Choice organizations may be "deemed" to meet quality assessment and performance improvement requirements if judged to do so by a national accreditation organization approved by HCFA and applying HCFA's standards for assessing compliance. This approach has much merit. It would allow plans to work with reviewers who already are familiar with their operations, creating obvious efficiencies and potential cost-savings. HCFA has failed, however, to establish procedures to implement the "deemed status" process. To date, HCFA has not designated any national accreditation organization for this purpose, nor has it issued policy guidance on how this process will work. HIAA urges Congress to direct HCFA to promptly institute a procedure for awarding deemed status since this process has the potential to reduce some of the substantial costs associated with HCFA's extensive quality assurance measures.

2. The Proposed Risk Adjustment Policy is Ill-Conceived

On January 15, 1999, HCFA announced its methodology for implementing the risk adjustment mandate set forth in the BBA. While HIAA believes that improved risk adjustment is an appropriate and essential long-term goal for the program, we have serious concerns regarding the current HCFA proposal, which calls for the initial use of only inpatient hospital data. During the Administration's proposed 5-year phase-in period, plans would receive capitated payments based on a blend of payment amounts under the current demographic system and the interim (PIP–DCG) risk adjustment methodology. For the year 2000, for instance, the HCFA plan calls for a separate capitated payment rate for each enrollee based 90 percent on the demographic method and 10 percent on the risk adjustment methodology. By 2004, payment rates would be based on comprehensive risk adjustment using full (*i.e.*, inpatient and other) encounter data and the demographic method would not be used. HIAA's concerns with this proposal are both practical and programmatic.

First, the practical. The time frame for implementation outlined by HCFA is simply far too short. Given the significant technological considerations involved, it is unreasonable for the agency to require that all Medicare+Choice organizations be able to provide physician, outpatient hospital, skilled nursing facility and home health data beginning as early as October 1, 1999. (HCFA has not yet identified a specific date by which this information must be provided, creating additional uncertainty.) The collection, verification, transmission and analysis of "representative" encounter data is a complicated endeavor. Capturing this data in a valid, accurate and transferable manner will be a major challenge for most plans. Indeed, some HIAA member companies that currently contract with HCFA do not have the technical capability to capture and transmit encounter data other than inpatient encounters. Nor do our members with PPO and similar network-style delivery systems have the capability to do so. They are simply not organized in a manner that will allow them to collect this level of data.

Even if the capital for such purposes can be arranged, HCFA's proposed time frame is insufficient to allow Medicare+Choice organizations to procure and install the required systems. Procuring systems that can accomplish these tasks requires very careful planning and assessment, review of the capabilities of competing technologies and vendors. Time is needed to install the systems, modify provider contracts if necessary to ensure adequate reporting to the Medicare+Choice plan, train the staff (both at the Medicare+Choice organization and provider locations) and verify and validate the data. All of these steps must be carefully executed or the system will fail. These obstacles to compliance cannot simply be wished away. Moreover, the imposition of these costs on all Medicare+Choice plans will make the development of rural plans even more difficult because they will continue to have fewer beneficiaries enrolled compared to plans in other areas.

The process by which information is communicated to, and received by, HCFA is likely to present significant technological problems as well, if past experience is any guide. HIAA members have experienced, and continue to experience, problems in ensuring that accurate inpatient hospital data is transmitted via Medicare fiscal intermediaries to HCFA.

Difficulties can also be expected as HCFA attempts to manipulate significant amounts of data for the first time using the proposed PIP–DCG risk adjustment model. The methodology developed by HCFA is complicated and requires numerous steps. The process is yet untested. HCFA faces a monumental task in getting the PIP–DCG system to work. We are awaiting the opportunity to review the plan-specific effects of the data collected to date. Moreover, as HCFA acknowledges, "the PIP–DCG model is [simply] an interim step towards implementation of a comprehensive risk adjustment model (*i.e*., one which uses diagnoses from all sites of service.)" HIAA strongly believes that the ambitious time frame proposed by the agency rests on a flawed premise: namely, that all of the anticipated technological and methodological problems can be resolved in the five-year window.

HIAA's doubts in this regard are heightened by the fact that planned implementation coincides, at least initially, with agency efforts to ensure Year 2000 readiness, both internally and in connection with Medicare+Choice organizations and other contractors. If HCFA transitions to risk adjustment before the necessary fixes are made and before reliable data are gathered and properly analyzed, the consequences could be catastrophic for individuals enrolled in Medicare+Choice plans, as well as the Medicare managed care program generally.

As if all this were not reason enough to delay implementation, HIAA has significant programmatic concerns regarding the proposed risk adjustment model. First, HIAA is concerned that variations resulting from excessive payments under the original Medicare fee-for-service program have been incorporated into the risk adjustment calculation. Additional, unnecessary hospitalizations that have occurred within the original Medicare Part A fee-for-service program, despite HCFA's attempt to fight this, are still significant. As a result, Medicare+Choice organizations will receive lower payments through the proposed risk adjustment methodology. HCFA should not penalize the managed care portion of Medicare for the program's failure to limit false or fraudulent claims and medically unnecessary hospitalizations. One approach to avoid this, would be to limit the use of risk adjustment so that the total amount paid to all Medicare+Choice plans is not reduced but instead redistributed among Medicare+Choice plans only.

Second, recognizing the fact that most federal agencies rely on sampling, HCFA's expectation of reported data on all individuals seems excessive. Given that even the more comprehensive risk adjuster will not be able to fully reflect all differences, HIAA believes that Congress should require HCFA to reexamine the use of plan-based sampling to reduce the administrative burden on the plans, reduce the potential for errors in the start-up phases, and increase the privacy of each individual's sensitive medical information.

Third, HIAA strongly believes that it is poor public policy to base risk adjustment—even temporarily—on inpatient hospital data only. Such an approach, even with the adjustments that HCFA has made to its initial risk adjustment proposal, would reward Medicare+Choice plans with excessive hospital use, and penalize plans that have effectively reduced inpatient hospitalizations and focused on providing more care on an outpatient basis. The incentives created by a risk adjustment methodology based exclusively on inpatient hospital data could result in increased inappropriate hospital use, increased avoidable costs, and a set back in the effort to realize greater efficiency in the health care system. Beneficiaries enrolled in plans with a relatively high proportion of members who receive care for expensive chronic illnesses outside the hospital setting would be particularly harmed.

For all these reasons, HIAA urges HCFA to delay the implementation date of risk adjustment beyond January 1, 2000. Since HCFA believes it does not have the authority to do this, Congress should revise the implementation date. While the effort to collect encounter data should proceed in a careful and deliberate manner, changes in payment methodology based on risk adjustment should not be implemented until complete and reliable encounter data are available. To ensure the validity of the data and a viable risk adjustment process, Congress should direct HCFA to (1) conduct a demonstration project aimed at validating the proposed methodology and (2) identify less costly and less data intensive ways of performing risk adjustment.

IMPACT OF BBA IMPLEMENTATION ON MEDIGAP PLANS

A number of HIAA members offer some or all of the Medigap standard plans. These members are concerned with the impact of the continuing implementation of

BBA on the premium increases they must pass on to the many seniors trying to maintain this valuable protection.

Seemingly socially responsible actions, allowing increased anti-selection when guaranteed issue opportunities are expanded beyond the first six months following attaining age 65 will require higher premiums. HIAA does not believe that only those seniors purchasing individual Medigap should have to bear this extra cost.

Proposals to expand Medigap drug coverage, legislation to allow specialty providers to select their highest cost patients and pay only the average rate while receiving Medicare and Medigap payments on every single one of these insureds, and regulations seeking to expand the scope of guaranteed issue are examples of why HIAA opposes mandates. In the name of expanding access, they result in increased costs, leaving more people without insurance.

Finally, the cost of Medicare supplement insurance, which covers more than 80 percent of Medicare beneficiaries, is increasing as a result of HCFA's delays in controlling the portion of hospital outpatient services which Medicare both doesn't cover and doesn't limit balanced-billing of the beneficiaries. Estimates of the cost of this delay are $570 million to be bore by Medicare beneficiaries or their Medicare supplement coverage while HCFA uses its resources to rush implementation of risk adjustment designed to save the government only $200 million in 2000.

SUMMARY AND CONCLUSION

If the Medicare program is to be sustained for the next generation of beneficiaries and beyond, it is crucial that the federal government employ every strategy appropriate to enhance quality health care options for beneficiaries and encourage the development of lower cost options rather than relying on punitive regulations which will reduce choice and funnel more people into the highest cost option—fee-for-service Medicare. The Medicare+Choice program already is at an early crossroad where improvements can allow it to flourish but neglect of necessary change will doom it to failure. It would be more wise, in the long run, for the government to employ market-oriented strategies to ensure that there are Medicare+Choice options available to beneficiaries and to create incentives for private health insurers and providers to deliver value in the context of the Medicare program. Because it is a critical building block in this market-based strategy, Medicare+Choice must be successful.

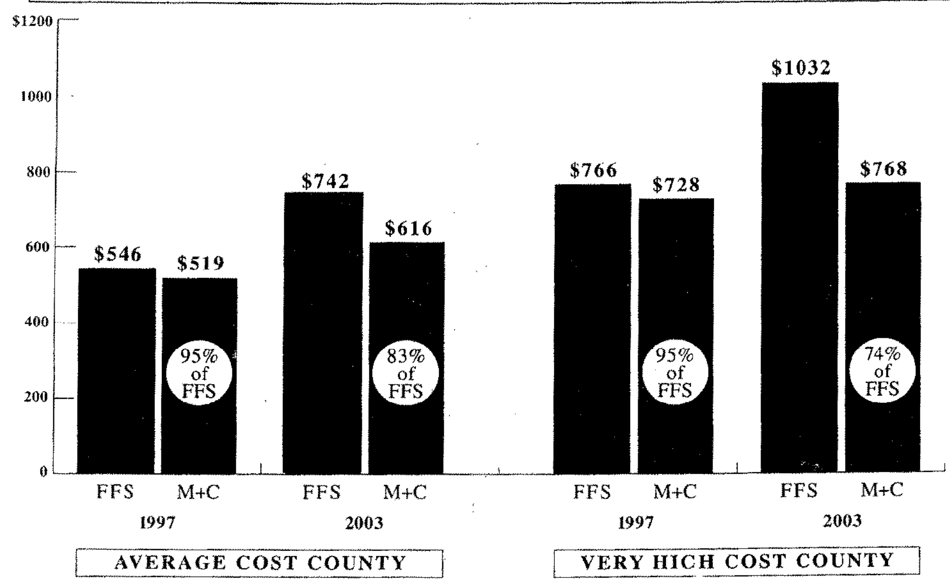
In summary, HIAA believes that the prospects for success will be greatly improved if the following steps are taken with respect to the Medicare+Choice program:

- Adjust the payment structure so that increases cover medical inflation;
- Issue revised regulations to reduce costly administrative burdens on small, rural and non-HMO plans;
- Change the due date of ACRs to November 1 to eliminate unnecessary risk;
- Delay and revise the proposed risk adjustment model to reduce the cost of reporting and system development; and
- Modify the role of risk adjustment so that overall revenues to the Medicare+Choice program are not reduced, but simply reallocated among plans based on the health status of enrollees.

A final word of caution: Congress must act quickly to direct HCFA to change course in the manner outlined and to find ways to reduce the regulatory burden of participating in the Medicare+Choice program if it wants the program to succeed. The time frames for critical decisions relating, for instance, to system investments are very short, particularly given HCFA's anticipated risk adjustment schedule. Thus, if Congress is to make adjustments to the program, it should act now.

Projected Payments per Medicare Enrollee

Fee-for-Service Plans vs Medicare+Choice Plans

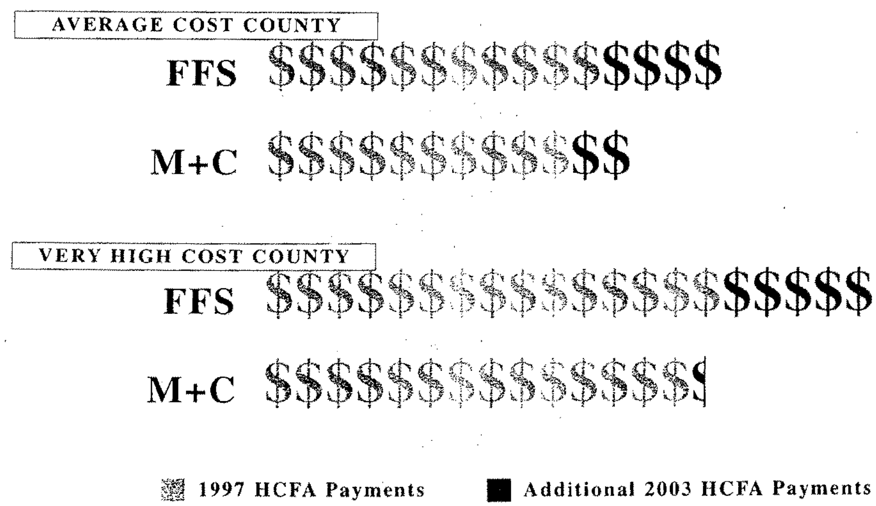


Source: HIAA estimates after risk adjustment based on PriceWaterhouse projection

HIAA®

Projected Payments per Medicare Enrollee

$ = Fifty Dollars



Source: HIAA estimates after risk adjustment based on PriceWaterhouse projection

HIAA®

INFORMATION TECHNOLOGY ASSOCIATION OF AMERICA
ARLINGTON, VIRGINIA
February 25, 1999

Chairman Willliam Thomas
Committee on Ways and Means
Subcommittee on Health
U.S House of Representatives
1102 Longworth HOB
Washington, D.C. 20515

Dear Chairman Thomas:

On behalf of the 11,000 direct and affiliate members of the Information Technology Association of America (ITAA), I would like to submit this statement for the printed record of the Subcommittee's February 11, 1999, hearing on the Management of the Medicare Program.

Since 1965, the Health Care Financing Administration (HCFA) has been tasked with the ever-increasing workload of administering the Medicare program through a limited group of Health Insurance Providers. ITAA strongly believes that it is time to leverage the free-market benefits of competition and flexibility by opening the Medicare claims processing bidding to a broader group of service providers, specifically, the information technology sector. We believe competition would better serve the customer, the American public.

In addition to their expertise in this area, the IT industry also builds and runs many of the systems and applications that HCFA's current contractors and their partners already utilize. The IT industry has extensive experience in the claims processing area in both the public and commercial sectors. An example, when Title 19 was enacted in 1965, it gave authority to the states to run the Medicaid, Program. Many of the states turned to cutting edge information technology companies who could excel in innovative solutions and adapt technology to best serve the customer in a timely fashion. ITAA firmly believes Medicare recipients too would benefit greatly from competitive bidding on claims processing and increasing the number of potential vendors. The IT industry also is not subject to some potential provider/contractor conflicts of interests.

ITAA supports the requests of current HCFA Administrator Nancy-Ann Min DeParle and her predecessors who state that the best solution for the government, and ultimately the customer, is to open up the Medicare program to increased competition in order to obtain the best management possible. If my staff or I can provide you with additional information on this subject, please let me know.

Sincerely,

HARRIS N. MILLER
President

Statement of Jack Pivar, President, National Association for the Support of Long Term Care (NASL), Alexandria, VA

Chairman Thomas: On behalf of the National Association for the Support of Long Term Care (NASL), I am pleased to submit the following written testimony to you and members of the House Ways and Means Health Subcommittee. This testimony is provided in response to the hearing held by your Subcommittee on February 11, 1999 to examine the Health Care Financing Administration's (HCFA's) ability to administer the current Medicare program.

NASL represents over 150 companies involved in the provision of services and supplies to the long term care industry and is the only organization at the national level concentrating its concerns and endeavors exclusively on legislative and regulatory matters regarding the ancillary service and product supply components to long term care facilities. NASL has worked closely with Congress and HCFA in developing the skilled nursing facility prospective payment system (SNF PPS) and in setting policy for (non-physician) Part B issues.

We appreciate not only the opportunity to comment, but also your continuing efforts to monitor HCFA's Medicare program management challenges. We, like you, agree that our nation's seniors deserve a well managed Medicare program that meets their health needs.

Essential to this examination, are the following principles:

• Beneficiary services should not be put at risk or disadvantaged by HCFA's computer systems problems.

• Clinical standards and program safeguards are being undermined by the inability of HCFA or its contractors to meet minimum performance standards.

• HCFA's administrative problems should not supersede the need to address real policy issues.

Each principle is discussed in greater detail below.

I. Beneficiary Services Should Not be Put at Risk or Disadvantaged by HCFA's Computer Systems Problems

• We are deeply concerned that HCFA has begun to cite Y2K issues as the primary reason for not moving forward on needed policy changes.

The skilled nursing facility prospective payment system must be finalized. SNF PPS, perhaps the biggest change to the industry since the beginning of the Medicare program, is currently being implemented pursuant to an interim final rule. HCFA now projects the final rule will be released in May. By definition, an interim final rule lacks the level of certainty needed by providers who are in the process of making costly changes to their own systems. By the time the final rule is released, providers will have worked under this interim rule for almost a year.

• Non therapy ancillary services must be appropriately funded. Early research findings show the Resource Utilization Group III (RUG III) system under the skilled nursing facility prospective payment system (SNF PPS) fails to adequately account for the costs of certain non-therapy ancillary services. These non-therapy ancillary services include prescription drugs, respiratory therapy, laboratory and certain complex medical equipment. Without the implementation of an interim solution, elderly Medicare beneficiaries may not have access to these services.

As evidenced by Representative Johnson's comments during the hearing, this problem is real. Nevertheless, potential, interim solutions continue to be rejected or limited by HCFA's Y2K computer compliance problems. Policy decisions directly affecting beneficiaries' needs are being dictated by the status of HCFA's "mission critical systems."

• Seniors must be afforded relief from the $1,500 therapy cap. Due to computer systems problems, HCFA has also been unable to fully implement the $1,500 on outpatient rehabilitation therapy services which has exacerbated the already inequitable impact of these financial limitations. The way HCFA has implemented the policy significantly impacts skilled nursing facility outpatient and rehabilitation facility patients, many of whom may exceed the cap. Nursing homes are put at risk to provide services without assurances such services will be reimbursed.

NASL continues to oppose as bad health care policy, the implementation of any type of arbitrary financial limitations on medically necessary services. We believe beneficiary needs should dictate the provision of services.

II. Clinical Standards and Program Safeguards are Being Undermined by the Inability of HCFA and its Contractors to Meet Minimum Performance Standards

We are concerned the integrity of the Medicare program is being compromised by management challenges within HCFA and its contractors. HCFA's lack of oversight of its contractors, coupled with inadequate training, has resulted in inconsistent and incorrect implementation instructions.

Criticisms have been leveled against HCFA, particularly by the Small Business Administration for HCFA's apparent disregard of the requirements under both the Administrative Procedures Act and the Regulatory Flexibility Act in promulgating regulations pursuant to the Balanced Budget Act of 1997.

Informal directives in the form of program transmittals and HCFA web site guidances are being used as pseudo rulemaking vehicles. Many of these directives have been inconsistent or contrary to the language of the interim final rule. Systems crucial to the SNF PPS transition, including the Arkansas Shared System, continue to remain inoperable seven months after the effective date of SNF PPS.

The following are just a few illustrative examples of management performance problems which are threatening to undermine services being provided under the Medicare program:

• Fiscal intermediaries under the Arkansas Shared System, have notified facilities they will be unable to pay claims pursuant to the physician fee schedule until "approximately" April. (See Mutual of Omaha notice attached.) According to the notice, Medicare claims will be temporarily paid under cost reimbursement methodology which will likely result in overpayments. These overpayments will in turn likely result in a future recovery of payments. In addition, the contractor predicts the coinsurance amounts calculated during the interim period will also be invalid.

- In a recent transmittal, HCFA instructed their contractors, as of April 5, 1999, to "return as unprocessable" all claims submitted by providers that are not Y2K compliant. At this time, a standard UB92 form capable of accepting that much data still does not exist.
- A provider's claims for outpatient services were recently rejected due to the inclusion of discipline specific modifiers on the claim. The provider was instructed by the fiscal intermediary to resubmit the claims, without the modifiers. A week later the claims were again rejected for not including discipline specific modifiers.
- A provider contacted their fiscal intermediary in an effort to obtain a copy of the physician fee schedules, and was told they would need to submit a Freedom of Information Act request to obtain the information.

III. HCFA's Administrative Problems Should not Supersede the Need to Address Real Policy Issues

As indicated in our February 22, 1999 letter to you (copy attached) we commend you and Representative Johnson for your leadership roles in addressing the crucial policy issues associated with the treatment of medically complex patients under the skilled nursing facility prospective payment system. We strongly support your recommendation that HCFA hold a Town Hall Meeting to discuss interim solutions to the problem and offer any assistance we may be able to provide in this regard.

HCFA's "short term" management challenges, while administrative in nature, can and do have a direct and immediate impact upon policy and the quality of services provided to beneficiaries. We thank you, Mr. Chairman, for not allowing the debate on HCFA's administrative performance, to eclipse the need to address the real policy issues that continue to exist.

We see the need for the following policy issues to be addressed:

1. *The skilled nursing facility prospective payment system structure is under-funded.*—Estimates show the actual reduction in Medicare skilled nursing facility prospective payment system expenditures has far exceeded original savings projections. Some portion of those savings needs to be returned to ensure success of the system as well as access and quality of services for nursing home residents.
2. *An interim solution must be implemented to address the non-therapy ancillary component of the skilled nursing facility prospective payment system.*—The skilled nursing facility prospective payment system (SNF PPS) fails to adequately account for the costs of certain non-therapy ancillary services including Without the implementation of an interim solution, elderly Medicare beneficiaries may not have access to these services.
3. *The $1,500 therapy cap placed on outpatient rehabilitation services must be repealed or modified to ensure seniors receive medically necessary rehabilitative services based on their condition and health and not on arbitrary payment limits.*—Senator Grassley is expected to introduce legislation which would exempt from the caps, Medicare beneficiaries meeting certain criteria. We encourage the introduction of a companion bill in the House.
4. *The merits of consolidating a number of services which historically have been infrequently delivered in nursing homes, must be re-evaluated.*—Due to Y2K systems problems, HCFA has delayed "until further notice" consolidated billing requirements for residents in a Part B stay. HCFA should provide the industry with a minimum of six months notification once the determination has been made to fully implement SNF PPS consolidated billing requirements. We hope Congress will use this time to reconsider what obligations should be placed on nursing homes such as services provided under agreement with suppliers of x-ray, clinical lab and ambulance services. The law creates an overwhelming burden upon the nursing home, and an administrative catastrophe for the Program.
5. *HCFA needs to establish an appropriate site of service differential for non-physician services shifted to fee schedules by the Balanced Budget Act of 1997.*—Establishing a site of service differential for services performed at a SNF or similar facility is needed to reflect the fact that different providers have different cost structures and that different costs arise in connection with the performance of similar services.

Conclusion

Severe Balanced Budget Act of 1997 implementation problems continue to exist, particularly within the skilled nursing facility prospective payment system. Computer systems capabilities are dictating decisions being made regarding beneficiaries' access to services. Policy decisions which should be made in accordance with the Administrative Procedures Act, are being implemented by informal notices. Providers are struggling to comply with rules that seem to change daily, only to find out the claims systems are not capable of processing the claims. HCFA and its contractors must be required to meet the same standards to which providers continue to be held.

Once again, Mr. Chairman, we appreciate your leadership and your continued attention on these matters. We request these comments be made part of the hearing record.

[Attachments are being retained in the Committee files.]

○